VERITY Mental Health Specialized Services Provider Manual

Provider Assistance: 503.988.5887

Produced by:
Multnomah County
Mental Health and Addiction Services Division
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MENTAL HEALTH SERVICES
PROVIDER MANUAL
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MULTNOMAH COUNTY
MENTAL HEALTH SYSTEM OF CARE

VALUES AND PRINCIPLES

Community members, providers, and Multnomah County staff have been working together since 1999 to design an improved Mental Health System for persons residing in Multnomah County. In September 2000, the Board of County Commissioners adopted values and principles for a "Consumer and Family Centered Mental Health System." Key elements of the Board of Commissioners adopted values and principles are summarized below:

- System Supports the Individual: The Mental Health system is organized to support and encourage each individual receiving services to achieve his or her full potential.

- Accessible: Individuals and families are able to access services easily, including a competent diagnosis, an appropriate and affordable menu of care, and prompt response to crises.

- Individualized: An individual's needs, goals, and preferences dictate the services provided.

- Seamless: Services from multiple programs and agencies are coordinated or integrated to better serve individuals and ensure that individuals can navigate through the system.

- Child and Family Focused: For children, services are child-centered and family focused; services support and strengthen the family system and will be guided by the best interests of the child or adolescent.

- Recovery Oriented: For adults, services are recovery-oriented with a focus on developing natural systems of support and self-determination.

- Age, Linguistic and Culturally Competent: Staff of all programs are sensitive and responsive to the elements of individual's identities, including age, ethnicity, race, language, religion, gender, sexual orientation, disability, and culture.

IMPLEMENTING MENTAL HEALTH SYSTEM VALUES AND PRINCIPLES

Evidence Based Practice:

As part of the on-going implementation of both the Adult and Children's Systems of Care, the Oregon legislature in 2003 passed Senate Bill 267 that required the progressive development of an Evidence-Based Practice (EBP) continuum in all of its funded services. This would require a transition from existing treatment strategies to an EBP continuum. Multnomah County believes that Evidence Based Practices, when performed in a manner consistent with scientific evidence (a concept described as 'fidelity' to a specified set of standards) will lead to a higher rate of positive outcomes for our clients.

Additionally, the System Of Care for Families was influenced by the Oregon Legislature's Budget Note HS-3, which mandated a Children's Mental Health System Change Initiative to improve the system for children with mental illness and their families. The Oregon State Addictions and Mental Health Division (AMH) was directed to take a series of actions by June 30, 2005, including:

- Integrate inpatient hospital, psychiatric residential, psychiatric day treatment, and community care in the local or regional managed care environments

- Ensure meaningful family involvement at policy, local or regional managed care system, provider, and individual child levels and explore mechanisms to ensure family involvement and control over some of the resource.

- Ensure continuous care coordination for children with serious mental and emotional disturbances.

- Create clinical and fiscal incentives to provide care in the least restrictive and most normative setting in the child's home community

- Encourage local or regional managed care organizations to create a flexible funding pool and to contract with one or more providers who are positioned to provide flexible response on a 24 hour, seven days a week basis, without requiring the children to enter a facility (even for a short period of stabilization) to access the services

This change shifts the risk and responsibility for children's psychiatric residential and children's psychiatric day treatment down to the local level and completes the integration of the full array of mental health services for Oregon Health Plan youth.

Community Mental Health Providers are responsible for assuring that a broad continuum of services with continuous care coordination is available for children meeting the level of need criteria for "integrated service array". This continuum includes:

- Screening
- Assessment and treatment planning

- Family involvement and supports including wraparound service delivery tailored to individual child and family needs
- Family education and support
- Skill training
- Mental health consultation
- Care coordination
- Supports and interventions in school-based setting whenever possible
- Psychiatry and medication management
- In-home and office-based individual and family therapy
- Respite services
- Crisis services
- Psychiatric day treatment
- Psychiatric residential treatment
- Inpatient hospitalization

Consumer and Family Involvement:

Consumer and family involvement in all aspects of the provision of mental health services is an essential core value of mental health services in Multnomah County. A recovery-oriented system of care requires that consumers and families be involved not only in treatment planning but also in the development of policy, program planning, service delivery, and evaluation of services.

The values of consumer and family involvement create opportunities for provider organizations to transform from the historical model of clinic-centered services to a true model of community based services where services are provided in the least restrictive setting, with the location of services and decision making resting at the community level. Community based services, in a system of care that is consumer and family focused, ensures that services are individualized and the needs, goals, and preferences of consumers determine the types and mix of services provided.

A community based, recovery-oriented mental health system of care also nurtures the development of consumer empowerment. Consumer empowerment is the antithesis of traditional clinic-based systems of care. Consumer empowerment "raises the bar" for provider organizations in their planning and implementation of recovery-oriented, consumer and family involved system of care. Desired results of consumer empowerment may be:

- Mental health service providers and consumers form equal partnerships
- Mental health service providers and families form equal partnerships
- Consumers, families, and providers mutually develop processes that will enhance informed consent for consumers and families
- Mental health service providers recruit and employ consumers in paid staff positions

- Mental health service providers recruit consumers and family advocates as members of advisory committees and Boards of Directors

Multnomah County is committed to the values of consumer and family involvement and consumer empowerment in development of a recovery-oriented, community based system of mental health services. Consumer and family involvement technical assistance and education are available to all contracted provider organizations through Provider Meetings, and phone consultation with the Quality Management Coordinator.

ACCESSING COUNTY SERVICES FOR CONSUMERS

MULTNOMAH COUNTY CALL CENTER

Multnomah County's Mental Health System's Call Center (MCC) provides a single point of access to the following services:

- Crisis Counseling and Coordination of Services
- 24-hour Mobile Outreach Service
- Verity Member Services
- Mental Health System Information and Referral
- Early Assessment and Support Alliance (EASA) Referral
- Mental Health Care Coordination
- Addiction Treatment System Referral
- Coordination with Involuntary Commitment Services
- Community Justice/Corrections Discharge Coordination
- Temporary Housing Assistance for Qualified Clients
- Flexible Service Vouchers for Qualified Clients
- Secure and Non-secure Transportation for Qualified Clients
- Acute Care Coordination
- Subacute Care Coordination
- Complaint Resolution
- Coordination with Mental Health Protective Services for Adults

The Multnomah Call Center also provides care coordination for any consumer in the mental health system experiencing a crisis. Call Center Acute Care Coordinators (ACC) insure that care for all consumers in crisis is coordinated such that two principles are maintained:

1. All system resources available to resolve a mental health crisis are available to all consumers in crisis.
2. All natural and paid care providers involved with a consumer in crisis come to agreement on a single treatment plan designed to resolve the crisis as quickly as possible.

Contracted providers are expected to notify the Call Center of any consumer in crisis and are expected to be responsive to any call from Call Center staff regarding consumers in crisis for which they are responsible.

- The Multnomah Call Center's 24-hour phone number is:
  (503) 988-4888 or 1-800-716-9769.
- VERITY Member Services (non-crisis information and referral) can be reached at:
  (503) 988-5887 or 1-888-620-4555.

MOBILE CRISIS AND OUTREACH UNIT

Project Respond, Multnomah County's mobile crisis and outreach unit, is available as a safety net 24 hours a day/7 days a week, to respond to consumers in crisis in the community, emergency rooms, and any situation involving both mental health and law enforcement personnel. Project Respond is available for people who are perceived to be in crisis due to a possible mental disorder, and who cannot come to a mental health center facility for screening or assessment. Project Respond responds to crises involving the general public as well as enrolled individuals enrolled in mental health services and their family members. Situations typically involve danger of harm to self or others or could reasonably be foreseen to escalate to that level.

Project Respond sends trained, respectful mental health professionals to work with the consumer, family, and their cultural and social supports. The goal is to assess and resolve current crisis and safety issues, and then develop a plan that will address longer-term needs. Strong emphasis is placed on consumer choice and creative solutions in the least restrictive environment. Services that Project Respond provides include:

- De-escalation of charged situations. If there is violence or the threat of violence, Project Respond works closely with police officers, all of whom are now trained in crisis intervention.
- Assessment of the safety of individual and community.
- Involuntary/voluntary hospitalization in as supportive and dignified manner as possible.
- Development of a short-term stabilization plan in the community.
- Problem-solving around medication access.
- Referral and linkage to resources in the community.
- Education, referrals for family and caretakers.

Requests for Project Respond are triaged and coordinated by the Multnomah Call Center.

Contracted providers are responsible for providing outreach service for consumers assigned to them when there is not an imminent risk of harm to self or others.

UREGENT WALK-IN CLINIC

The Urgent Walk In Clinic (UWIC) is available on a "no appointment necessary" basis to provide intake and referral, crisis assessments and stabilization, and access to prescribers. The UWIC is designed for consumers who are new to the mental health system. The UWIC can encourage consumers to enroll in mental health services with any mental health service provider. Consumers already assigned to a contracted outpatient provider can be seen at the UWIC under the following circumstances.

- The consumer chooses to access services at the Walk in Clinic for a particular urgent need.

- The contracted outpatient provider is unable to secure access to needed services in a timely manner *and* failure to do so is likely to result in an imminent need for a more intensive level of service.

In both circumstances, the UWIC provides necessary services to resolve only the immediate needs of the consumer. Providers should make every attempt possible to manage urgent situations before sending consumers to the UWIC. Ongoing care is the responsibility of the contracted provider.

The UWIC, its location, and hours of operation are:

Cascadia Plaza
2415 SE 43rd Street
Portland, Oregon (West entrance off Division)
Sunday-Saturday; 7:30 am-10:30 pm

FLEXIBLE SERVICES FUND

Vouchers for housing, transportation and other flexible services are available for temporary situations caused by mental disorders, in order to assist with keeping OHP beneficiaries and indigent persons from requiring needing higher levels of care. Most services can be accessed through the Multnomah Call Center, the Urgent Walk-In Clinic, or through Project Respond.

- **Temporary Housing Assistance** can include vouchers for hotels as well as limited monetary assistance on an individual basis.
- **Transportation** should be accessed through Tri-Met for all OHP Plus eligible consumers. For indigent persons, transportation, secure transportation, taxi vouchers, and Tri-Met tickets are available.
- **Other Services** can include food, clothing, or any item that will help to resolve temporary situations caused by mental disorders in connection with helping to keep OHP beneficiaries and indigent persons from needing higher levels of care.

Accessing Flexible Services:
Vouchers for these services are available through the Call Center, through the Urgent Walk-in Clinic, and through Project Respond. All clinicians are required to do an assessment and formulation of the consumer's clinical presentation prior to issuing a voucher.

Vouchers that are issued by the Walk-in Clinic and by Project Respond are only available for consumers at the time of service with that program.

In order to justify the use of a Flexible Service Voucher, the formulation must conclude that the Flexible Service will help to resolve a temporary situation caused by a mental disorder in connection with helping to keep the OHP beneficiary or indigent person from requiring a higher level of care. The Walk-in Clinic and Project Respond clinician fills out the voucher in its entirety and has (if possible) the consumer sign in their presence on the first consumer signature line. The clinician should clearly print their name and telephone number on the voucher. The pink (bottom) copy is forwarded to:

Call Center Office Assistant
421 SW Oak Street, Suite 520
Portland, OR 97204

The consumer presents the top two copies to the merchant and signs the second consumer signature line in the presence of the merchant. The merchant retains the yellow copy and sends the top (white) copy to the Call Center Assistant at the above address for payment. The Call Center Assistant matches the pink and white copies of the vouchers and approves payment. If there is any disparity between the pink and white copies, the Call Center Office Assistant contacts the issuing clinician to confirm the intended level of services. Call Center Acute Care Coordinators may also issue vouchers. They follow the same procedure detailed above.

School-Aged and Early Childhood Outpatient Flex Funding Criteria:

School-aged and Early Childhood providers have flex funds to be used solely for the benefit of children with a mental health diagnosis where the use of those funds could prevent the following:

- Decompensation
- Assist in environmental stability
- Enhance child and family engagement
- Increase independence from formalized services

Flex funds can be used for:

- Temporary shelter
- Basic care needs
- Transportation
- Behavior incentives
- Developmentally appropriate activities
- Food for group, child and family team meetings
- Educational activities

Providers will determine no other funding or resource is available to meet above criteria by documenting evidence of at least two telephone or person to person requests to other funding resource in the client's chart. All flexible fund purchases must be tied to a child's treatment plan, and should be reflected in the client's chart. The County will not reimburse for any purchases that are illegal or could present a risk of harm.

Invoices must be submitted by the 20th of the month and contain the following elements to be reviewed and recommended for payment:

- Name of Child Served with the Flex Funds
- Medicaid Number or Raintree Number
- Date of Birth
- Description of Item or Service Purchased; and
- Treatment Goal Tied to Purchase

Please send monthly invoices to:

Multnomah County
Mental Health and Addiction Services Division
421 SW Oak Street, Suite 520
Portland, OR 97204
Attention: Business Services

TRANSPORTATION

OHP Plus Consumers:
Medicaid Transportation and Secure Transportation for consumers with OHP Plus is accessed by calling Tri-Met Medicaid Transportation Program at (503) 802-8700. Generally, secure transportation is appropriate when a consumer is involuntary, or at risk of engaging in dangerous behavior, e.g. jumping out of a taxi. An older child who is involuntarily being transported at the request of their guardian is a good candidate for secure transportation, as is any consumer on a Director's Custody Hold, when the police are not themselves providing transportation. When these criteria are not met, regular medical transportation may be used.

OHP Standard Consumers and Indigent Persons:
For indigent persons, the referent calls the Multnomah Call Center to request transportation. A Call Center Acute Care Coordinator (ACC) triages the call and, together with the referent, decides whether secure or non-secure transportation is appropriate. For secure transportation, the ACC arranges transport with Northwest Regional Secure Transportation directly at (503) 348-4907. For non-secure transportation, the ACC may make arrangements with Radio Cab, Greyhound Bus line etc.

WHAT IS THE MULTNOMAH TREATMENT FUND AND THE INDIGENT MEDICATION PROGRAM?

Multnomah Treatment Fund (MTF) is a safety net program for children and adults who do not qualify for Oregon Health Plan Standard or Plus benefits due to income or lack of documentation of legal residency; whose family income is below 200% of the Federal Poverty level, who have no mental health insurance benefit, are unable to pay for services on their own, **AND** who meet the clinical criteria outlined in ORS 430.675:

"Priority 1 is defined as those persons who, in accordance with the assessment of professionals in the field of mental health, are at immediate risk of hospitalization for the treatment of mental or emotional disorders, or are in need of continuing services to avoid hospitalization, or pose a hazard to the health and safety of others, and those persons under 18 years who, in accordance with the assessment of professionals in the field of mental health, are at risk of removal from their homes for treatment of mental or emotional disturbances, or exhibit behavior indicating high risk of developing disturbances of a severe or persistent nature."

In addition, adults will meet clinical criteria for MTF if they are in imminent jeopardy of loss or removal of children due to their mental disorder and/or at risk of homelessness, incarceration, hospitalization, or dangerousness.

MTF may also be used as a funding source while individuals are obtaining OHP coverage or whose coverage has lapsed provided that they meet clinical criteria as outlined above.

Indigent Medication Program:
Verity Providers also have the ability to request up to a 60 day supply of psychiatric medications for consumers who meet the above clinical and financial MTF criteria. Clients are not required to have an Outpatient authorization in place in order for Providers to request Indigent Medications.

Please visit the Verity Provider webpage (under Useful Provider Links) to learn how to apply for MTF and Indigent Medications through Multnomah County's Mental Health and Addiction Services Division.

http://www.co.multnomah.or.us/dchs/mhas/provider.shtml

INTERPRETER SERVICES

Accessing Interpreter Services:
Multnomah County Mental Health and Addiction Services Division, as a Managed Mental Health Care Organization, is responsible for costs of language interpreter services for its Verity consumers. In addition Multnomah County Mental Health and Addiction Services Division also covers the costs of interpreter services for individuals receiving services through Multnomah Treatment Fund (MTF). Contracted interpreters provide services for non-English speaking Verity and MTF consumers as well as Verity and MTF consumers requiring oral/sign language interpreter services.

NOTE: It is the expectation of the Mental Health and Addiction Services Division that if a contracted Provider is able to utilize internal staff to provide interpreter services for their consumers, that this is provided and billed for with applicable CPT codes as appropriate before attempting to arrange services with an outside interpreter.

Procedure for Obtaining Language Interpreter Services:

Providers must confirm a consumer's eligibility:

Multnomah County Mental Health and Addiction Services Division Verity consumers will have a Medicaid number (make sure that Multnomah County Verity is their MHO)

Multnomah County Mental Health and Addiction Services Division MTF consumers will have an assigned Raintree number given to them by County staff after their Provider obtains an approved authorization for services.

NOTE: for MTF consumers only, if a Provider has requested a Screening/Triage, Assessment Only, or an initial 60-day authorization, a Raintree number will not have been assigned yet. These consumers can be identified with the letters "VPI" for initial eligibility confirmation.

Interpreter services may be arranged through vendors listed on the Verity Provider webpage:

http://www.co.multnomah.or.us/dchs/mhas/provider.shtml

Call and arrange for an interpreter to be present as needed and ask that the service be billed to the Mental Health and Addiction Services Division of DCHS using the applicable unit code or PIN. Specify the name, language, place, date, time and approximate duration of the services and prepare to brief the interpreter if necessary.

For cancellations, if possible, please contact the appropriate agency by 12:00pm the business day before the scheduled appointment date.

Tell the interpreter service to specify on the County's invoice, the program in which the consumer is enrolled.

ADULT SYSTEM OF CARE

A new Multnomah County Adult System of Care was introduced in 2006 in order to infuse Evidence-Based Practice into service delivery. Not only were specific Evidence-Based Practices offered as stand alone contracts, Verity began offering an enhanced rate for certain services provided in the community. Contractors are rewarded for aligning their service delivery with more out-of-facility, community-based activity. The design also allows the standardization of service delivery reporting, bringing contractors into alignment with federal regulations on claims submission. This design reflects a fee-for-service reimbursement method for contracted Community Mental Health Providers. The model requires the use of a Level of Care assessment tool called the "LOCUS" for Verity adult consumers. There are five categories of service delivery that outline a level of care expectation for adults. They are:

- I. Assertive Community Treatment (ACT)
- II. Dialectical Behavior Therapy (DBT)
- III. Services for Severely Mentally Ill (SMI)
- IV. General Outpatient Mental Health Services
- V. Respite

MHASD attempts to meet all the clinical needs of Verity members by also contracting with individual providers with unique skill sets. Medically appropriate services provided by these providers are pre-authorized to meet the needs of members who require or request a service that cannot be met through routine mental health services.

Adult Specialty or Exceptional Needs mental health services include:

- Assertive Community Treatment (ACT)
- Dialectical Behavior Therapy (DBT)
- Electroconvulsive Therapy (ECT)
- Providence Home Health, Intensive Outpatient Day Treatment and St. Vincent Intensive Outpatient Eating Disorder
- Verity credentialed psychiatrists
- Verity credentialed PMHNP providers who provide assessment & medication management services

Primary or Lead Provider: Verity members will receive, whenever possible, mental health services from a single agency, referred to as the Primary or Lead Provider. The member will be considered "attached" to their Lead Provider under the following circumstances:

- Adults receiving general outpatient services, whose Provider has an approved authorization for LOCUS level 0 (zero), 1 (one), 2 (two), or 3 (three) services.
- Adults receiving basic services for the severely mentally ill whose Provider has an approved authorization for LOCUS level 2 (two), 3 (three), or 4 (four) services.
- Adults, whose Provider has an approved authorization for ACT services.
- Adults, whose Provider has an approved authorization for DBT during a specific course of DBT treatment.

For adults, these authorizations may be approved for up to 12 months.

Please see **Medical Necessity Criteria** for all adult and child mental health services as well as other utilization management information on the Verity Provider webpage:

http://www.co.multnomah.or.us/dchs/mhas/provider.shtml

FAMILY CARE COORDINATION TEAM

Multnomah County operates a Family Care Coordination Team (FCCT) that is implementing the Children's System Change Initiative for the State of Oregon and is designated to manage access to residential, day treatment, Intensive Community Based Treatment Services (ICTS), and other out-of-home mental health services for Multnomah County children and their families. The FCCT offers direct clinical care coordination, and case consultation functions to the service providers. The goal of the FCCT is to assure the provision of clinically appropriate, evidence-based, cost effective, accessible services in the least restrictive and most culturally appropriate environment to enrolled individuals. To this end, the objectives of the FCCT are:

- To identify children and their families who have not benefited from a lower level of community based mental health services and are at risk of out-of-home placements and/or inpatient care due to their mental illness.
- To identify services and service delivery systems for above mentioned targeted children and families, that are clinically appropriate, evidence-based, cost effective, accessible, and in the least restrictive and most culturally appropriate environment.
- To facilitate the delivery of the identified services to targeted children and families, within their community and in a systematic manner, which is focused on meeting individual and family needs, protective of individual rights, comprehensive in scope, and expeditious in operation.
- To ensure the continuation of appropriate services to the individual and families after the cessation of FCCT services

The County FCCT will fill the leadership role with the family in creating child and family cross system teams within the agencies that serve the identified youth and their family in order to ensure access to the most effective level of mental health services. At a minimum a Child and Family Team is composed of the family, FCCT and child when appropriate. The staff provides care coordination to assist families in accessing mental health services for high needs children who are at risk for or are currently residing in out-of-home placements due to their mental health needs. Child and Family Teams are responsible for creating, implementing, reviewing and revising service coordination plans for children and families.

The FCCT is the sole access point to the Integrated Services Array (ISA). The Integrated Services Array describes a full continuum of mental health services available to children who are eligible for the Oregon Health Plan who have serious psychiatric illnesses. Based on the level or Need Determination process a child who is not Medicaid eligible may also receive the Integrated Service Array. Services will be based on family choice and medical appropriateness. The array of services includes:

- A comprehensive mental health assessment;
- Psychiatric evaluation and medication management;
- Care coordination;
- Home and community based individual, group, and family therapy;
- Culturally competent, home and community based individual or group skills training,
- Respite care and family support;
- Safety planning and 24/7 Crisis services;
- In school and after school treatment and/or behavioral supports;
- Psychiatric day or partial day treatment, (in communities with funding for this);
- Psychiatric residential treatment services;
- Acute or sub-acute hospitalization.

The FCCT in conjunction with the Child and Family Cross System Team determine the type and mix of services to best meet the child's needs and strengths. The Team manages access to all mental health services for youths being placed outside the home for treatment reasons, with certain exceptions (e.g. the privately insured).

The FCCT assist in ensuring smooth transitions and combined care plans between Inpatient and ISA, and between ISA and other mental health and addictions services when necessary.

Referrals come to the team from many places, including hospitals, psychiatric residential treatment programs, Department of Human Services child welfare, Juvenile Justice, Oregon Youth Authority, family court, the homeless youth network and other venues that frequently come into contact with children and youth who do not have readily identifiable families or need to be out of the home due to an emotional/behavioral disorder.

Other team responsibilities include:

- Triage and technical assistance for clinical, placement and systemic issues
- Coordination of families' needs in multiple systems of care
- On going care coordination for youth who have come into state custody and need ISA level mental health and addiction services, or who are receiving intensive treatment services outside of the home or clinic
- Facilitating successful discharge as soon as possible
- Working with the state Services to Children and Families to identify and develop family resources if none are directly available
- Assisting community providers in development of innovative and wraparound services using the Systems of Care model

The FCCT pay special attention when children enrolled in the Intensive Service Array are transferring from one county to another county. Through state-wide cooperation, a **County to County Transfer Protocol Agreement** has been established between state-wide Mental Health Organizations that have Family Care Coordination Teams.

This agreement is intended to be a guideline for Verity FCCT staff to ensure the smoothest transition of services for those children moving between counties.

Agreement for Transfer Protocol for ISA Cases
Transferring to another County/MHO

This protocol is intended to give consistency to the transfer process and is based on the shared values of continuity of care for clients and their families, and assumptions of good intent by MHO colleagues involved in this process. In addition, we recognize that each MHO will want to do its own clinical review, child and family team and service coordination plan. This is to ease the transition for the child and family until those things can occur.

1. Outgoing MHO will alert the Receiving MHO/County a minimum of 30 days prior to transfer. As feasible based on the timing, the Receiving MHO agrees to be involved in a minimum of two child and family team meetings prior to the transfer. This may be by phone if necessary.

2. Outgoing MHO will submit to Receiving MHO: Updated Service Coordination Plan and Level of Need determination paperwork.

3. Receiving MHO will review ISA eligibility status and Service Coordination Plan sent by Outgoing MHO. For the purposes of a transition without disruption of services, the Receiving MHO will accept ISA eligibility from Outgoing MHO, with the understanding that they may at some point find the client does not meet their ISA eligibility criteria.

   Outgoing MHO will complete a "transfer" CASII at time of transfer. Receiving MHO can choose to use that CASII for state reporting, or do a new one.

   Outgoing MHO will send the most recent ISA Progress Review and most recent BERS as part of the transfer packet. The Receiving MHO can choose to use this data or complete a new one.

4. During the transition process, a Service Coordination Plan to be implemented in the receiving community should be discussed and agreed to by the Child and Family Team. If this is not possible, the Receiving MHO will accept the service array that is in place from Outgoing MHO for an interim period (up to 90 days) while the new Child and Family Team is getting into place.

   ** Step #4 (accepting current service array) may not be applicable for those children moving into a community where there are limited community resources. The Outgoing MHO and Receiving MHO will still follow steps #1-3 as part of the transition for that child into a new community.

** Once client has transferred to the new MHO, they will then be responsible for revising the service plan/ service array if needed.

COUNTY QUALITY MANAGEMENT PROGRAM

QUALITY MANAGEMENT

Quality Management for Community Based Mental Health Providers

Multnomah County Mental Health and Addiction Services Division is committed to facilitating and recommending tools to the contracted agencies for the implementation of a broad array of high quality services to meet the mental health/substance abuse needs of consumers. Hence, Multnomah County Mental Health and Addiction Services Division is committed to working with the agencies to continuously improve quality of care for the purpose of ensuring positive treatment outcomes for individuals covered under the Oregon Health Plan.

Multnomah County Mental Health and Addiction Services Division believes that this commitment to continuous quality improvement is best realized when the principles of quality management are the foundation for ongoing program operations. We invite and expect the providers to join us in this endeavor by utilizing quality management principles in their daily operations and through significant, meaningful quality improvement activities that are linked to the Providers' Annual Quality Management Work Plans.

Organization of Provider Quality Management Programs

All Providers are expected to have a formal operational Quality Management Program, including Quality Program Descriptions and an Annual Quality Program plan, updated annually. The program should contain the following organizational elements:

- A Quality Management Coordinator or Director;
- An Annual quality improvement work plan detailing the domains, indicators, measurement method(s), and outcomes in the coming year along with time frames for accomplishing each; and
- Continuous Quality Improvement training for all staff, preferably beginning with senior management staff.

Providers offering multiple levels of care, service types or having multiple clinical sites should also have a Quality Assurance/Improvement committee, which oversees the implementation of Continuous Quality Improvement throughout the organization/agency. At a minimum the, QA/QI committee should include senior staff and the Quality Management Coordinator or Director.

Upon request, providers will submit to Multnomah County Mental Health and Addiction Services Division updated Quality Management Plans, program descriptions and work plans, along with the name of their Quality Management Coordinators/ Directors.

Functions of Provider Quality Management Programs

Provider Quality Management Programs and Annual Quality Management Plans should include quality measurement and improvement activities for the following:

- Quality Indicators aimed at measuring, monitoring, managing and improving key internal processes or program operations (Access, Quality of Service, Integration and Coordination, Prevention, Outreach and Education, Consumer & Family Center Practices and Outcomes), all of which are written in the context of quality care.

- Treatment Outcome Studies such as Evidence Based Practices, the percentage of treatment goals achieved and/or Functional Status Assessment, administered at intervals during the course of treatment; and

- Member satisfaction surveys.

Providers are required to submit the results of quality measurement and improvement activities in these areas to Multnomah County Mental Health and Addiction Services Division upon request.

Participation in Quality Measurement and Improvement Initiatives

On an ongoing basis, the Multnomah County Mental Health and Addiction Services Division Quality Management committee will be reviewing a range of quality measurement and improvement initiatives. Providers are expected to participate in these initiatives when requested and to incorporate the results into their quality management plans. Common examples of quality measurement and improvement initiatives in which Multnomah County Mental Health and Addiction Services Division will request Provider participation include:

- Random reviews of Medical Records: For most Providers, the Quality Management Program will review a representative sample of charts at least every three years. Providers are expected to ensure that Multnomah County Mental Health and Addiction Services Division has access, within 2 working days of notice, to the records of all consumers. The purpose of these chart reviews shall include:

    a) Determining whether the clinical or medical necessity criteria for the level of care provided was established,

    b) Assessing the quality of care provided,

    c) Verifying the inclusion of required medical record elements.

The results of these reviews will be shared with Providers to be used in future quality improvement initiatives and to refine the Providers' utilization management practices. Multnomah County MHASD Quality Management Program may request focused chart reviews at any point if evidence or over-utilization or under-utilization of services, or when other quality issues are identified.

- Outcome studies and Member Satisfaction Surveys: Providers will be asked to participate in the administration of these studies. Aggregate results from all studies will be shared with participating Providers and other interested parties when available. No Provider-specific data will be supplied to anyone other than the Provider unless the Provider so directs.

Provider Quality Improvement Goals

The Provider is, at a minimum, required to:

- Have on-site and make available to Multnomah County Mental Health and Addiction Services Division when requested a Quality Management Plan. Random audits will be conducted as necessary.

- Submit, upon request, a current annual Quality Management Program Description, and Work Plan, along with the name of the Quality Management Coordinator/Director.

- Incorporate Verity Quality Management Committee's Quality Improvement Goals and measures into the Provider's annual Quality Improvement Plan.

- Participate as requested by Multnomah County Mental Health and Addiction Services Division in meetings and workgroups to develop strategies to ensure that the annual Quality Improvement Goals are met.

The provider will:

- Provide Multnomah County Mental Health and Addiction Services Division with a written evaluation of progress made toward meeting the annual Quality Improvement Goals.
- Review its annual Quality Improvement Plan Performance Agreement concerning the requirements of the annual Quality Improvement Goals.

If Multnomah County Mental Health and Addiction Services Division notifies the Provider in writing that its performance is not in compliance with the requirements for the annual Quality Improvement goals, the provider shall prepare and submit a corrective action plan to Multnomah County Mental Health and Addiction Services Division for its approval within required time frames, as determined by Multnomah County Mental Health and Addiction Services Division.

CRITICAL INCIDENTS

Critical Incident Reporting Policy

Critical incident reporting to Multnomah County's Mental Health and Addiction Services provide an important element in the quality management of services. Such communication is essential so that all parties in our mental health service system are aware and able to respond to inquiries about critical situations, to trigger investigations when additional information is deemed necessary, and to facilitate improvement in service quality.

A critical incident involving a child means the incident is a result of staff action or inaction that punishes, endangers or otherwise harms a child enrolled in a community mental health program service to include residential or sub-acute care.

In accordance with Oregon Administrative Rule (OAR) 309-032-0970 (8) a critical incident involving a child shall be reported to the State Addictions and Mental Health Division by telephone and in writing, one working day of any critical incident affecting a child, stating the course of action to be taken by the Community Mental Health Program to investigate or otherwise resolve the incident. A copy of the critical incident report shall be sent to Multnomah County's MHASD Quality Management, fax #: **(503) 988.5870**.

An adult critical incident is defined as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, or clear and present risk to public safety. Serious physical injury is defined as the loss of limb, or function or injury that without medical care would result in impairment or death. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a chance of serious adverse outcome.

Critical incidents in adult State licensed and funded residential care shall be reported to the MHASD Quality Management staff immediately with a faxed report (see above fax number) within 24 hours. (Please visit the following web page to download the MHASD Critical Incident Reporting Form.)

http://www.co.multnomah.or.us/dchs/mhas/critical_incident_report_form.pdf

Reviewable events include but are not limited to:

- The death of a consumer who has an active treatment authorization.
- The serious (requiring emergency department treatment or hospitalization) injury of any consumer in active treatment determined by the agency to be related to mental health issues.
- The death of or serious injury of another individual caused by a consumer with an active treatment authorization.
- Any other incident deemed necessary by the contracted provider and/or VERITY staff.
- Any consumer with an active treatment authorization charged (new charges only) with an assault involving a weapon or serious bodily harm, sexually-related charges, such as, sexual assault, sexual abuse, rape, sodomy, etc.
- Any active consumer charged with an act of arson, or reasonable suspicion that an active consumer set fire/s that caused significant property damage or injury to self/others.
- Any stalking behavior by a consumer in active treatment.
- Abuse allegations against agency personnel providing mental health services to VERITY members.
- A suicide attempt or self-injury with significant intent to cause self-harm or death. In particular, those events that without medical/psychiatric care would result in impairment or death.
- A medication error, which may result in a consumer death, serious injury, or hospitalization.
- Police Intervention: involvement by law enforcement personnel who enter a mental health facility in response to a crisis call from the agency, to control disruptive client behavior.

Upon becoming aware of an incident, VERITY contracted Providers shall notify the Quality Management Coordinator within 24 hours, complete a written critical incident report within 30 days, and fax the critical incident report to VERITY Quality Management.

Please report Critical Incidents to:

Quality Management Coordinator
Mental Health & Addiction Services Division
421 SW Oak Street, Suite 520
Portland, OR 97204
(503) 988-5464 x24424
Fax: (503) 988-5870

The Mental Health and Addiction Services Division Quality Management Director shall refer all reports to the quality assurance process for completion of an investigation. A fact – finding inquiry will be conducted in all cases. Monthly summary reports shall notify the Department Director of all critical incident reports and actions. In cases of death by unnatural causes or cases of adult abuse, the Multnomah County MHASD Protective Services Investigators will conduct an investigation according to the Office of Investigation and Training Abuse and Critical Incident procedure. The Director/Clinical Supervisor of the contracted agency shall schedule a peer review meeting the investigator within 30 days of the event.

MEMBER RIGHTS AND RESPONSIBILITIES

All Verity members receive a Member Handbook that outlines services, the Oregon Health Plan, and a listing of community based mental health agencies. The Member Handbook includes Member Rights and Responsibilities and information about rights to confidentiality. The Member Rights and Responsibilities should be posted in all major areas of consumer use, including but not limited to: Urgent Walk-in Clinic, Drop-In Centers, waiting areas and lobbies, in accordance with OAR 410-141-0320. Providers must also provide written information about child and family rights according to OAR 309-032-1290. At the time of admission the provider must distribute the child and family rights to the person legally giving consent to treatment of the child. In addition, these rights must be explained orally at the time of admission to the person giving consent to treatment and to the child, in a manner appropriate to the child's developmental level. If the child is initially served in a crisis situation, these rights must be explained as soon as clinically practical, but not more than five working days from the initiation of services if the child who received the crisis service remains in service.

VERITY Members have the Right to:

- ✓ Be treated with respect, courtesy, and dignity
- ✓ Be given information about mental health needs and treatment and have this information explained in a manner that is understandable to the member
- ✓ Participate in choosing a mental health provider
- ✓ Refer oneself directly to a provider for Covered Services without first having to gain approval from another provider

- ✓ Have access to Covered Services and obtain covered Preventive Services which at least equals access available to other persons served by provider
- ✓ Participate in planning and decisions about treatment including information about his/her condition and covered/non-covered services to allow an informed decision about proposed treatment(s)
- ✓ Have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines
- ✓ Talk to provider and expect that what is said will be kept confidential (Refer to the section on Confidentiality).
- ✓ Have a clinical record maintained which documents conditions, services received, and referrals made
- ✓ Have access to one's own clinical record, unless restricted by statute and to request that the record be amended or corrected as specified in 45 CFR part 164
- ✓ Have a copy of his/her clinical record transferred to another provider
- ✓ Get mental health care without a long delay
- ✓ Receive information about rights, responsibilities, benefits available, how to access services covered by VERITY and what to do in an emergency
- ✓ Provide consent to treatment or refuse care and talk with provider about what this might mean
- ✓ Receive necessary and reasonable services to diagnose the presenting condition
- ✓ A second opinion, at no cost from a qualified healthcare professional within the network or outside the network if a qualified healthcare professional is not available
- ✓ Know how to make a complaint or file a grievance about your provider to VERITY or about VERITY and receive a timely response
- ✓ Request a Department of Human Resources hearing, including an Expedited Hearing if they feel the problem is urgent or emergent and cannot wait for the normal hearing process
- ✓ Request Continuation of Benefits until a decision in a hearing is rendered, however, the member may be required to repay any benefits continued if the issue is resolved in the favor of Verity
- ✓ Receive mental health care regardless of age, race, religion, national origin, gender, or sexual orientation
- ✓ Receive emergency mental health care 24 hours a day, 7 days a week
- ✓ Change primary mental health provider
- ✓ Have someone to help talk to provider if language interpretation is needed, or are hearing or speech impaired at no cost to the consumer. An interpreter can be available during appointments and in dealing with VERITY.
- ✓ To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- ✓ Receive in writing, a notice in a readable format, when a Service or benefit is cancelled reduced or changed. This is called a Notice of Action.
- ✓ Appeal when a service has been denied if they are the person consenting to treatment
- ✓ Receive a notice of an appointment cancellation in a timely manner
- ✓ Execute a statement of wishes for treatment, including the right to accept or refuse treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990-Patient Self-Determination Act

VERITY Members have the Responsibility to:

- ✓ Choose a mental health provider
- ✓ Help provider get old mental health records or fill out new ones
- ✓ Honestly share concerns about mental health needs
- ✓ Ask questions about things that are not clear
- ✓ Help decide treatment plan and approve the plan before it starts
- ✓ Treat provider and VERITY staff with respect and courtesy
- ✓ Keep appointments and be on time. Call provider when late or can't keep the appointment.
- ✓ Bring DMAP Medical Care ID whenever care is needed
- ✓ Pay their monthly OHP Premium on time if so required
- ✓ Use only selected provider for mental health needs, in an emergency, services from someone else may be needed
- ✓ If emergency mental health services are used when out of the area, members must let VERITY know within three days
- ✓ Tell provider if there are changes to address or phone number

VERITY Child and Family Members enrolled in Intensive Community Based Treatment Supports & Services have these additional Rights to:

- ✓ Consent to treatment in accordance with ORS 109.640 & 109.675. (Minor children can give informed consent for outpatient diagnosis and treatment for a mental or emotional disorder in certain circumstances according to ORS 109.640 and 109.675.)
- ✓ Refuse Services if they are giving consent and have any serious consequences explained to them if they do so
- ✓ Confidentiality in accordance with ORS 179.505, 107.154, 418.312, and any other applicable state and federal regulation
- ✓ Consent to a Disclosure of clinical records, when required, usually the person consenting to treatment
- ✓ Immediate inspection of the clinical record unless access is restricted in accordance with ORS 179.505. (A copy of the record is to be provided within five working days of a request for it. Fees may be associated with coping of multiply copies.)
- ✓ Participate in Treatment Planning and service coordination and review, at least every three months, the child's progress toward treatment goals and objectives
- ✓ Have a custodial parent or legal guardian of any minor, age 14 or older who has consented to outpatient treatment or diagnosis, be involved before the end of treatment unless the parent refuses, there are clear clinical indications to the contrary, the child has been sexually abused by the parent or the child has been legally emancipated by the court or has been self sustaining for 90 days prior to obtaining treatment
- ✓ Make informed consent to fees for services

VERITY Child and Family Members enrolled in Children's Intensive Mental Health Treatment Services have these additional Rights to:

- ✓ Humane treatment in the least restrictive environment
- ✓ Have identifying and clinical information about the child protected in provider publications such as newsletters and publications

- ✓ Private and uncensored communications by mail, telephone and visitations unless the treatment provider documents in the child's record that, in the absence of this restriction, significant physical or clinical harm will result to the child or others
- ✓ Uncensored communication with licensed attorneys at law and the state protection and advocacy agency
- ✓ Personal possessions including the ability to wear their own clothing and keep personal possessions
- ✓ Receive educational services in the least restricted environment
- ✓ Refuse to perform routine labor tasks for the provider and to receive reasonable compensation for all work performed other than personal housekeeping duties and chore
- ✓ Be free from unusual or hazardous treatment procedures and to not participate in experimental treatment procedures without voluntary informed consent
- ✓ Freely exercise recognized and accepted religious beliefs and other civil rights
- ✓ Participate regularly in developmentally appropriate indoor and outdoor play

Confidentiality

All information regarding Verity Members mental health needs and services is confidential. This means anything in medical records, and anything told to providers or Multnomah Verity staff, will remain confidential as discussed below.

Information will not be shared with anyone without written permission of Member except when permitted or required by law. Situations in which Verity staff and staff of provider agencies are legally required to share information include:

- ➢ Reporting to Child Protective Services or law enforcement agency when there is a reason to suspect the abuse or neglect of a child.

- ➢ Reporting to law enforcement officers and the intended victim when there is a clear and serious threat of homicide or intent to do serious bodily harm to another person.

- ➢ Reporting abuse of an elderly person or a person with a mental illness or developmental disability to the appropriate agency.

- ➢ Reporting imminent risk of suicidal behavior to the appropriate caretaker.

- ➢ Responding to a doctor or the hospital in the event of a medical emergency.

- ➢ Responding to a court order requiring the release of a client's record.

DECLARATION FOR MENTAL HEALTH TREATMENT

Declarations for Mental Health Treatment

All contracted mental health providers must maintain written policies and procedures, applicable to all capable adults who are receiving mental health treatment by or through the organization in accordance with ORS 127.703. General provisions or ORS 127.703 include:

Delivering to individuals the following information, in written form, without recommendation:

- Information on the rights of the individual under Oregon law to make mental health treatment decisions, including the right to accept or refuse mental health treatment and the right to execute declarations for mental health treatment.

- Information on the policies of a contracted provider organization with respect to implementation of the rights of the individual under Oregon law to make mental health treatment decisions.

- A copy of the declaration for mental health treatment set forth in ORS 127.736.

- The name of a person who can provide additional information concerning the forms for declarations for mental health treatment.

- Documenting in a prominent place in the individual's medical record whether the individual has executed a declaration for mental health treatment. However, an organization need not furnish a copy of the declaration for mental health treatment to an individual if the organization has reason to believe that the individual has received a copy of a declaration within the preceding 12 month period or has a validly executed declaration.

- Educating the organization's staff and the community on issues relating to declarations for mental health treatment.

A Guide to Oregon's Declaration for Mental Health Treatment is provided on the Verity Consumer webpage located at:

http://www.co.multnomah.or.us/dchs/mhas/consumer.shtml

PROVIDER REPORTING

QUALITY IMPROVEMENT WORKPLAN

Your agency is expected to develop, maintain, update, and submit to Multnomah County 60 days after the effective date of contract start, a written Quality Improvement Workplan. The Work Plan shall have a planned, systematic process for monitoring, evaluating, improving and measurement methodology for the following domains:

- ✓ access to services
- ✓ quality of service
- ✓ integration and coordination

- ✓ consumer and family centered practices
- ✓ prevention, education, and outreach
- ✓ outcomes.

Specific to the consumer and family involvement domain, the Quality Improvement Workplan must address, at a minimum, the following elements:

- ✓ Consumer and family involvement in policy development, program planning, service delivery, and evaluation, including decision-making boards. Consumer and family involvement on these agency boards should be, at minimum, 25% of total membership and shall consist of representatives which include the following constituent groups: adolescent consumers, adult consumers, older adult consumers, family members of child and adolescent consumers, and family members of adult and older adult consumers.

- ✓ Outreach and education for consumers and families, including notification of opportunities for peer support, self-help, and family peer support in languages commonly spoken in Multnomah County.

- ✓ Recruitment and hiring of consumers and family members as providers. Consumer and family-led training that supports attitudes and services that focus on strengths and embrace respect and dignity of consumers and families

- ✓ Notification to consumers, at least yearly, of opportunities to participate in the aforementioned activities.

Contractor shall demonstrate that findings are used to improve access and remove barriers to covered services; improve capacity to provide covered services in a timely manner; improve the quality of care provided and the coordination of benefits; and strengthen and expand prevention, early intervention and education services. This plan must contain measurable objectives, timelines, and persons responsible for all elements.

Agency QI Workplans will be submitted to Multnomah County for review by the Quality Management Coordinator at the following address:

Quality Management Coordinator
Mental Health and Addiction Services Division
421 SW Oak Street, Suite 520
Portland, OR 97204

OR

Electronically: MHO.Reports@co.multnomah.or.us

Should the services provided under this section be subcontracted, it is the responsibility of the agency to require the subcontractor to submit a Quality Improvement Workplan 60 days after the subcontract is in effect.

The current QI Workplan Evaluation Form used by Multnomah County to evaluate your proposed plan is included in this Provider Manual as Attachment A.

CULTURAL AND LINGUISTIC COMPETENCY PLAN

Your agency is expected to develop and implement a performance based, written cultural competency plan in accordance with this Multnomah County Cultural Competence Standard and Self Assessment Tool. In order to provide assistance with this process, the following suggested areas toward achieving the required standards are provided:

Non – Discrimination

Does the non-discrimination policy need to be revised to meet the County Standard?
Is non-discrimination/EEO policy posted?
Is there a plan for a periodic review for the Affirmative Action plan?

Staff Diversity

Does diversity of staff reflect the consumer population served or living in the provider's service area?
Is diversity represented throughout the ranks of the organization?
Are issues of diversity raised as possible reasons why staff might choose to leave the agency?

Accessibility to Services

WELCOMING ENVIRONMENT
Are furnishings comfortable?
Are photographs present of persons of all cultures served?
Would consumers find artwork from their culture in the common areas and offices?
Is the reading material available in the waiting areas of interest to the various groups served?
Does the environment provide literature or artwork representative of the life experiences of the consumers served?

ACCESS
Can people who are hearing, sight, and mobility impaired easily access the agency?
Do ADA improvements need to be made/updated?
Is public transportation easily accessible and information about this included in the agency literature?

LANGUAGE
Is multi-lingual literature available that represents consumers served?
Are signs and general information available in multiple languages?
Does at least one clinical staff person speak the language of a specific consumer group? Can the provider demonstrate that the bilingual staff person is competent in both English and the other language?
Does agency have resources available for referral of consumers whom they cannot serve due to language barriers?
What provisions does the agency have to assure effective communication with Limited English Proficient people?

Training

Does the agency have regularly scheduled trainings that focus on cultural issues?
Does information regarding cultural training opportunities get circulated to staff?
Does staff have the opportunity to receive training specific to their cultural interests or needs?
Have cultural diversity issues been incorporated into all employee performance evaluations?
Is there training specific to delivery of culturally competent services?

Culturally Competent and/or Specific Programs/Services

Does agency base service development on the demographics of the populations in the service area?
Is data regarding the consumers served by the agency used in service development and marketing efforts, especially when some populations are underserved?
Do language barriers impact the effectiveness of services? Are there means of addressing these barriers?
Have cultural competencies been developed and implemented?

Community Outreach

Does the agency have printed materials that are specific to the cultural groups served by the agency?
Are all targeted cultural groups in the service area served effectively by the agency? If not, what can be done to improve services to under served groups?

Evaluation

Is the cultural competency plan reviewed and update regularly?
Do staff and consumers review the cultural competency plan and do they have opportunity for input?
Are community focus groups ever conducted with consumers or potential consumers to evaluate service provision?
Have performance measures been developed?
Are complaint trends reviewed for issues related to cultural competency?

All provider agencies are required to perform an internal assessment of their agency's cultural and linguistic needs, a "Needs Assessment" based on the domains and questions above. **Unless otherwise instructed, this Needs Assessment is due annually on January 2nd. Providers may submit their needs assessment to: MHO.Reports@co.multnomah.or.us.**

VERITY AND MULTNOMAH TREATMENT FUND
SERVICE AUTHORIZATION AND
CLAIMS MANAGEMENT

Service Authorization

VERITY:

The Clinical Integration Manager or 'CIM' Authorization and Claims Management Database is the electronic tool offered by Verity's Third Party Administrator (Performance Health Technology or PhTech) for the input of service authorizations. Detailed instructions on how to become a user and log on to CIM can be obtained by contacting the PhTech Helpdesk at (503) 584-2169.

Depending on the level of care being requested, Providers may either directly enter an authorization into CIM for Verity eligible members or submit a clinical packet for County Care Coordination review before authorization input by County staff.

Providers will be required to submit an initial authorization either into CIM or for County review no more than 90 days after the first date of service.

MULTNOMAH TREATMENT FUND:

The CIM database is also used to track service authorization for Multnomah Treatment Fund (MTF) consumers. All MTF authorization requests are reviewed and entered by County Care Coordinators.

See Attachment E for County Policy and Procedure on the MTF authorization process for adults and children.

Claims Payment

Unless explicitly instructed otherwise by contract, it is preferred that Providers submit fee-for-service claims electronically to PhTech for prompt payment. Providers are encouraged to contact the PhTech Helpdesk to secure an FTP site for electronic submission. That number is: **(503) 584-2169.** Submission of any claim for payment must be done **no later than 90 days after the service date or the claim may be denied.**

All claims resubmission requests submitted by provider must be received by PH Tech within 90 days from the date of service to be reconsidered for payment.

Providers may also submit paper claims for payment. Paper CMS (HCFA) 1500 forms must be **received** no later than 90 days after the service date at the following address:

Performance Health Technology
P.O. Box 5490
Salem, OR 97304

Division of Medical Assistance Programs corrections

Once corrected claims have been processed by Multnomah County's Third Party Administrator, they will be transmitted to DMAP. DMAP puts data through another validation process. Should there be an error causing DMAP to pend a record, Multnomah County in conjunction with the Third Party Administrator will contact providers as needed to assist with any corrections required by DMAP. These corrections must be submitted to Multnomah County's Third Party Administrator within 30 days of the request for corrections. This requirement applies to **all** funding streams, i.e. Verity, MTF etc.

CLIENT PROCESS MONITORING SYSTEM (CPMS)

The Client Process Monitoring System (CPMS) is a State processing system that tracks community-based treatment services for persons with mental illness, persons with developmental disabilities, and persons with substance abuse problems. Information from this system is combined with other information from other systems to create one integrated database under a single unique client identifier. The integrated database contains Consumer specific data across programs statewide and provides a Continuity of Care picture for individual Consumers. This information allows the State Addictions and Mental Health Division (AMH) to manage publicly funded mental health services, respond to legislative inquiries, and demonstrate cost effectiveness under the federal requirement for the OHP Medicaid Demonstration Project and Children's Health Program.

General Provisions:

A. Contractor shall submit CPMS data for anyone who receives any amount of Covered Services provided by public funds, (except for acute inpatient hospital services which shall be reported on OP/RCS). Public funds include Medicaid, Medicare, OHP Members, and state/county/federal grants. For each client enrolled on CPMS the contractor must maintain a file that includes, but is not limited to, documentation of the primary diagnosis, a psychosocial work-up (which might include a family history, prior treatment information, etc.) and a treatment or training plan.

B. Contractor must have the clinician that assesses the client complete the CPMS form. Portions of the form require clinical judgment and certain information is gathered only during the client assessment.

C. Contractor shall submit CPMS data for any OHP Member who is civilly committed to the custody of DHS under ORS 426.130.

D. AMH shall process all CPMS data through the Mental Health Information System (MHIS). AMH shall "pend" CPMS data that cannot be processed because of missing or erroneous date.

E. AMH shall notify Contractor monthly of all pended CPMS data.

F. Contractor shall correct pended CPMS data within 30 calendar days of notice.

Timelines:

A. Contractor must complete enrollment forms within 7 working days of the first face-to-face treatment contact (usually the initial assessment.)

B. Contractor must complete termination forms no later than 30 calendar days after the last face-to-face treatment contact.

C. Contractor must complete corrected Monthly Management Report (MMR) by the first working day of the month following receipt. NOTE: If there are no mistakes on the MMR you do not need to mail back to CPMS.

D. Contractor shall work with AMH Data Base Analyst in developing, formatting, and testing the CPMS to ensure reporting of accurate data.

Data Transmission and Format:

A. Contractor shall submit all CPMS data to AMH via electronic media in the specific CPMS format. Contractor may obtain reporting protocols upon request through the AMH Data Base Analyst.

B. Contractor may request electronic access to the MHIS for Utilization monitoring purposes.

Providers are encouraged to visit the following link for up to date CPMS information:
http://www.oregon.gov/DHS/mentalhealth/tools-providers.shtml

COMPLAINT/GRIEVANCE PROCESS

Multnomah County Mental Health and Addiction Services Division
Guidelines for Provider Complaint/Grievance Process.

DEFINITIONS:
A Member complaint or grievance is defined as *an oral or written communication, submitted by an OHP Member or an OHP Member Representative, which addresses issues with any aspect of the Provider's operations, activities, or behavior that pertains to: the availability, delivery, or quality of care, including utilization review decisions that are believed to be adverse by the OHP Member.*

An Informal Complaint/Grievance is defined as an incident or concern identified verbally related to a practitioner or staff member. This level of complaint/grievance requires minimal research, and often is resolved through education, negotiation, mediation, or case management.

A Formal Complaint/Grievance is an incident or concern that is identified either verbally or in writing to the staff member(s) responsible for resolving complaints/grievances and that requires formal review by the Contracted Provider Agency's Quality Assurance Coordinator and/or Provider Agency's medical director.

When submitting a complaint directly to Verity, OHP Verity consumers are required to use the Department of Human Services (DHS) Oregon Health Plan Complaint Form:

http://dhsforms.hr.state.or.us/Forms/Served/HE3001.pdf

All non-OHP (Multnomah Treatment Fund) consumers may use the Mental Health and Addiction Services Division Complaint Form:

http://www.co.multnomah.or.us/dchs/mhas/multco_complaint_nonohp.pdf

PROVIDER PROCEDURE GUIDELINES:

For the purpose of this section, "consumer" refers to either the consumer or the consumer's representative.

Please note: a Provider's complaint/grievance procedure should only apply to those situations in which the consumer expresses concern or dissatisfaction about any matter **other than an "Action". (See information below on Notice of Action).** As per 42 CFR 438.408 all Providers shall have written procedures to acknowledge the receipt, disposition and documentation of each complaint/grievance from consumers. Providers' written procedures for handling complaints/grievances, shall at a minimum:

- Address how the Provider will accept, process and respond to each complaint/grievance from a consumer including:
  1) Acknowledgment to the consumer of receipt of each complaint/grievance
  2) Ensure that consumers who indicate dissatisfaction or concern are informed of their right to file a complaint/grievance and how to do so;
  3) Ensure that each complaint/grievance is transmitted timely to staff that have authority to act upon it;
  4) Ensure that each complaint/grievance is investigated and resolved in accordance with all applicable rules; and
  5) Ensure that the Providers' staff person(s) who makes decisions on the complaint/grievance must be person(s) who are
     a. not involved in any previous level of review
     b. Health Care Professionals who have appropriate clinical expertise in treating the consumer's condition if the complaint/grievance concerns clinical issues; and
     c. qualified to make denials based on lack of medical necessity
  6) Describe how Provider informs consumers both orally and in writing (OAR 410-141(G)(b)) about the Providers' complaint/grievance procedures
  7) Designate the Providers' staff member or a designee who shall be responsible for receiving, processing, directing, and responding to complaint/grievances
  8) Include as part of the Providers' process the requirement for complaint/grievances to be documented in a log to be maintained by the Provider in a manner that is consistent with OAR 410-141-0266.
- Providers shall provide consumers with reasonable assistance in completing forms and taking steps relating to filing and disposition of a complaint/grievance. This includes, but is not limited to, providing Interpreter Services where appropriate.

- Providers shall assure consumers that complaints/grievances are handled in confidence consistent with ORS 411,320, 42 CFR 431.300 et seq, the HIPAA Privacy Rules, and other applicable federal and state confidentiality laws and regulations.
- Providers procedure shall provide for the disposition of complaints/grievances within the following timeframes:
  1) Provider shall resolve each complaint/grievance, and provide notice of the disposition, as expeditiously as the consumer's health condition requires, within time frames established below;
  2) For standard disposition of complaints/grievances and notice to the affected parties, within 5 working days from the date of the Providers' receipt of the complaint/grievance, the Provider shall either:
     a. Make a decision and notify the consumer; or
     b. Notify the consumer in writing that a delay in the Providers' decision, or up to 30 calendar days from the date the complaint/grievance was received by the Provider, is necessary to resolve the complaint/grievance. The written notice shall specify the reasons the additional time is necessary.
- The Providers' decision about the disposition of a complaint/grievance shall be communicated to the consumer orally or in writing with the timeframes specified above.
  1) An oral decision about a complaint/grievance shall address each aspect of the consumer's complaint/grievance and explain the reason for the Providers' decision;
  2) A written decision must be provided if the complaint/grievance was received in writing. The written decision shall review each element of the consumer's complaint/grievance and address each of those concerns specifically, including the reasons for the Providers' decision.
- A consumer who is dissatisfied with the disposition of a complaint/grievance may present the complaint/grievance to the Oregon Health Plan Client Advisory Services Unit (CASU).
- All complaints/grievances made to the Providers' staff person designated shall be entered into a log (see below) and addressed in the context of the Providers' Quality Improvement Workplan and overall Quality Management structure.
- Providers will post the Multnomah County Mental Health and Addiction Services Division Member Complaint/Grievance Procedure Poster, provided by the Division in all consumer waiting areas.
- In addition to any internal complaint forms, providers will make available to consumers copies of the DHS Oregon Health Plan Complaint Form, Notice of Complaint/Grievance Process, and if applicable, information on the State of Oregon Administrative Hearing Process.

Both Informal and Formal Complaints/Grievances made by Multnomah County Mental Health and Addiction Services Division consumers **that are resolved within the Provider Agency** will be submitted in a County approved spreadsheet with identifying codes.

Please send this *monthly* Provider Complaint Log by the fifth (5th) of each month to:

Multnomah County
Mental Health and Addiction Services Division
Quality Management Coordinator
421 SW Oak Street, Suite 520
Portland, Oregon 97204

OR

Electronically: MHO.Reports@co.multnomah.or.us

CONSUMER COMPLAINT/GRIEVANCE PRESENTED TO VERITY QUALITY MANAGEMENT COORDINATOR:

Multnomah County Mental Health and Addiction Services Division encourages all consumers to attempt to resolve complaints or concerns directly with the provider or provider agency. If the consumer expresses discomfort about attempting to resolve the issue directly, or if the consumer has stated that he/she has attempted to resolve the issue but was not satisfied with the outcome, the Verity Quality Management Coordinator can initiate, at the request of the consumer, the Verity complaint process.

All complaints or concerns received by the Verity Quality Management Coordinator shall be responded to promptly within the established guidelines set forth by the State Mental Health Organization (MHO) Agreement above. **It is critical that Providers respond promptly when contacted by the Verity Quality Management Coordinator in order for established timeframes to be upheld.**

NOTICE OF ACTION

Contracted Providers are required to issue a Notice of Action to Oregon Health Plan (Verity) consumers only within timeframes specified and in accordance with the State MHO Agreement:

Question: What exactly is an **Action**?

Answer: 2010 State MHO Agreement, Exhibit A defines **Action** as:

a) The denial or limited authorization of a requested Covered Service, including the type or level of service (this is typically done at the Verity or Health/Mental Health Plan level.)
b) Reduction, suspension, or termination of a previously authorized service;
c) Denial, in whole or in part, of payment for a service (this is typically done at the Verity or Health/Mental Health Plan level)
d) Failure to provide services in a timely manner;
e) Failure to act on Grievances and Appeals within specified timeframes; or
f) Denial of a request to obtain services outside the Provider Panel (this is typically done at the Verity or Health/Mental Health Plan level)

Question: When is a Provider required to issue, either by mailing or in person, a Notice of Action to a consumer?

Answer: When a Provider takes or intends to take any Action, including but not limited to, reductions, suspension, discontinuation or termination of a previously authorized Service, the Provider shall mail a written Notice of Action within timeframes specified.

Question: What are the required timeframes for issuing a Notice of Action?

Answer: The Notice must be mailed at least 10 calendar days before the date of Action, except in certain circumstances. Providers may mail a Notice not later than the date of Action if:

1) the Provider receives a clear written statement signed by the OHP Member that he or she no longer wishes Services or gives information that requires termination or reduction of Services and indicates that he or she understands that this must be the result of supplying that information;
2) The OHP Member has been admitted to an institution where he or she is ineligible for Covered Services,
3) The OHP Member's whereabouts are unknown and the post office returns Provider's mail directed to him or her indicating no forwarding address
4) The Provider establishes the fact that another state, territory, or commonwealth has accepted the OHP Member for Medicaid services;
5) There is a change in the level of medical care that is prescribed by the OHP Member's Provider;
6) The date of Action will occur in less that 10 calendar days, in accordance with 42 CFR 438.12()(5), related to discharges or transfers and long-term care facilities;
7) There is factual information confirming the death of the OHP Member (Notice would be sent to the Member's guardian)

Question: Is there a required format for a Notice of Action?

Answer: Yes, please see Verity webpage for a sample form.

VERITY APPEAL PROCESS

Multnomah County Mental Health and Addiction Services Division
Appeal Process

Verity, as required in the State MHO Agreement, has in place a system for OHP Members to Appeal a Notice of Action issued by their Provider (see definition of **Action** above.) Appeal means a request to the Health/Mental Health Plan (Verity) for review of an Action. Member requests for an Appeal may be made in writing to Verity.

Please visit the following web page to download a copy of the Verity Mental Health Organization Member Appeal Form:

http://www.co.multnomah.or.us/dchs/mhas/verity_complaint_grievance_form.pdf

STATE ADMINISTRATIVE HEARING PROCESS

An individual who is or was an OHP Member at the time of a Notice of Action is entitled to an Administrative Hearing by the Addictions and Mental Health Division (AMH) regarding a Notice of Appeal Resolution by the Health/Mental Health Plan (Verity) that did not resolve the Appeal wholly in favor of the OHP Member.

If, at the OHP Member's request, the Provider continued or Verity reinstated Services while the Appeal was pending, those Services must be continued pending the Administrative Hearing until one of the following occurs:

1. The OHP Member withdraws the request for an Administrative Hearing
2. Ten calendar days pass after Verity mails the Notice of Appeal Resolution, providing the resolution of the Appeal against the OHP Member, unless the OHP Member within the 10-day timeframe, has requested an Administrative Hearing with continuation of benefits until the Administrative Hearing decision is reached
3. A final order is issued in an Administrative Hearing adverse to the OHP Member; or
4. The time period or Service limits of a previously authorized Service have been met.

When an Administrative Hearing is requested by an OHP Member who has exhausted Verity's Appeal process, the Provider shall cooperate as requested by Verity with providing relevant information required for the Administrative Hearing process by AMH, including any attempts at resolution by the Provider.

PROVIDER SPECIALTY REPORT INSTRUCTIONS

Instructions for Completing the Mental Health Services Provider Specialty Report

If required by contract, Provider organizations shall complete the Mental Health Provider Specialty Report (formally known as the Practitioner Report) in the Multnomah County required format either on a computer diskette using the Multnomah County approved Excel spreadsheet format, or electronically to: MHO.Reports@co.multnomah.or.us

The Provider Specialty Report is submitted **quarterly**, 30 calendar days after the current quarter. The report is submitted to:

Quality Management Coordinator
Multnomah County
Mental Health and Addiction Services Division
421 SW Oak Street, Suite 520
Portland, OR 97204

Contracted Provider organizations shall list the names of all clinicians (QMHP, QMHA, and other health care professionals) providing covered services for OHP beneficiaries. Please Note: for PRTS, PDTS and Respite Care providers it is not necessary to report at the clinician level. Please see report template at the *Verity Forms* link on the Verity Provider webpage. For employed persons whose duties may be administrative, if such persons are responsible for oversight of clinical or case-management, the amount of time recorded for such persons shall be limited to the proportion of time spent conducting clinical oversight or case-management activities.

Providers shall indicate the FTE of the individual and the average number of hours worked each week over the calendar quarter for employed health care professionals. The standard work week, for the purposes of this report, shall be 40 hours.

The Provider Specialty Report shall include the following data elements:

1. Name of the Provider agency

2. Report Date

3. End dates for all ex-employees for the reporting quarter

4. Listing of the name of each employed clinician providing mental health services to OHP members by degree or license, indicating the following categories:

   A. MD (Physician/Psychiatrist)
   B. PMHP (Psychiatric Mental Health Nurse Practitioner)
   C. PhD (Licensed Clinical Psychologist)
   D. LCSW (Licensed Clinical Social Worker)

5. For each subcontracted Provider agency, list the name of employed clinical persons providing covered services or case management activities, and indicate the average hours per week each is engaged in OHP activities for the Primary Provider. Use the following categories:

   A. MD (Physician/Psychiatrist)
   B. PMHP (Psychiatric Mental Health Nurse Practitioner)
   C. PhD (Licensed Clinical Psychologist)
   D. LCSW (Licensed Clinical Social Worker)
   E. QMHP (Qualified Mental Health Professional)
   F. QMHA (Qualified Mental Health Associate)
   G. PARA/Non-D (Paraprofessional/Non-Degree)

6. List the names of all subcontracted Providers not mentioned above with whom the Primary Provider has contracted for the provision of covered services such as hospitals, respite care providers, etc.

7. In addition, Providers shall list for each clinician any specialty services or Evidence-Based Practices the clinician provides, including their competency level. Examples are as follows:

Early Intervention; infants and toddlers	Therapeutic Preschool
Pediatric; developmental, behavioral	Geriatrics; elderly
Art Therapy	Adoption; pre/post adoption
Strength-Needs Based Assessment & Treatment	Foster Children/Families
Gay/Lesbian Youth	Homeless
Handicapped	Home-Based
School-Based	Community-Based
Special Education	Spiritually-Based (please list specific religion)
Alternative Counseling (please list	Eating Disorder Treatment

specific culture)	
Firesetter Evaluation/Treatment	Sex Abuse Treatment
Domestic Violence Treatment	Serious & Persistent Mental Illness (SPMI) Chronically Mentally Ill (CMI)
Serious Emotional/Mental Disorders in Children / Adolescent	Wandering Behavior
Eating/Drinking non-food items or fluids (pica, psychogenic polydypsia)	Dual Diagnosis / Mental Retardation Developmental Disabilities (MR/DD)
Dual Diagnosis / Substance Abuse (Chemical Dependency, Alcohol & Drug, UA)	Personality Disorders (Borderline Personality Disorder)
Grief & Loss	Attention Deficit Disorder
Dementia	Brain/Head injured
Medical needs (specific medical conditions such as Diabetes, seizures, or chronic health, medically fragile)	Assertive Community Treatment (ACT)
Transition-Aged Youth (TAY)	Medication Management
Clinical Supervision	Care management (case manager)
Crisis Intervention	Skills Training; Activities of Daily Living (ADL) Family Support, wrap around, individualized, parent training, parent support, flexible services
Vocational (vocational rehabilitation, career, employment)	Community Support Services (CSS)
Dialectic Behavioral Therapy (DBT)	Housing
Therapeutic Foster Care	Cultural Assessment Tool

Multicultural Specialty

Providers are asked to indicate the competency level for each language specialty (see template report).

For technical assistance and a copy of the Multnomah County approved format, Provider agencies may access the *Verity Forms* link on the Verity Provider webpage, or contact the Mental Health and Addiction Services Division Quality Management Coordinator at (503) 988-5464, x24424.

OUTPATIENT ACCESS & REFERRAL REPORTS

If required by contract, Providers are expected to complete **monthly** accessibility reports. This reporting is designed to provide feedback to Verity on a consumer's ability to access services according to timelines set forth by the State. Your program's goal should be to provide rapid access to services in order to

decrease risk of out-of-home placement, incarceration, or acute hospitalization of consumers. Provider's performance measures include:

- For Urgent and Emergency Services, consumers must receive an initial face-to-face or telephone screening within 15 minutes of contact to determine nature and urgency of situation. (Target 100%)
- For Emergency Services, consumers will receive timely Covered Services within time frames identified in screening or within 24 hours of request, whichever is less. (Target 100%)
- For Urgent Services, consumers will receive timely Covered Services within time frames identified in screening or within 48 hours of request, whichever is less. (Target 100%)
- For non-Emergency and non-Urgent Services, consumers will be seen for Intake Assessment no later than 14 calendar days after request for Covered Services. (Target 100%)

For outpatient services, Access Reports are due **monthly**. Please visit the *Verity Forms* link on the Verity Provider webpage for templates.

If required by contract, Children's Providers of Intensive Services are expected to complete **quarterly** referral (access) reports. The format of this report may be designed by the Provider, but shall include the following elements at minimum:

-Consumer Identifier (if available)
-Date of Birth
-Oregon Health Plan number
-Family Care Coordinator's referral date
-Treatment Initiation Date
-Percentage of children and families referred that initiate treatment within three (3) business days.

This report is designed to provide feedback to Verity on the percentage of children and families referred that initiate treatment within three (3) business days of a Family Care Coordinator's referral. Your program's goal should be to provide rapid access to services in order to decrease risk of out-of-home placement, detention, and acute hospitalization of children/youth served. Provider's performance measure is:

- Percent of children and families referred that initiate treatment within three (3) business days of FCCT referral. (Target 90%)

PROVIDER OUTCOMES REPORTING

Adults:

Satisfaction Survey Collection:

Verity asks that general outpatient consumers complete the Mental Health Improvement Program (MHSIP) Satisfaction Survey (see www.mhsip.org for survey information). In collaboration with outpatient agencies, survey collection occurs for a two-week period at each agency site. Collection will occur generally in May with appropriate agency and consumer follow-up between collection periods. Focus of follow-up will depend on survey results. Historically the focus has been around Quality and Outcome information.

Verity will provide the following:

- Confidential collection boxes for each agency site
- Satisfaction surveys in English and foreign language translations
- Data entry of surveys
- Verity Survey results

Agency expectations during collection period include the following:
- Pick up and drop off of confidential collection boxes at Verity identified location
- Confidentiality boxes and copies of MHSIP surveys should be provided in an easily accessible location for consumers.
- If consumers do not typically come in to the agency site, alternative collection methods should be determined with Verity Quality Management Staff.

Outcomes Report:
Agencies are expected to utilize an outcomes instrument (OQ45 or other Verity approved instrument) to aide in treatment planning. Agencies shall identify a Verity approved tool, determine how the tool will be used most effectively, and how information will be reported to Verity. A report of the full contract year's outcome information is expected at the end of the contract year.

Children:
Satisfaction Survey Collection:
Children receiving mental health outpatient services and their guardians are surveyed using the Youth Satisfaction Survey/YSS and Youth Satisfaction Survey for Families/YSS-F (see www.mhsip.org for survey information). The YSS is filled out by 14-18year olds while family members of any aged child fill out the YSS-F. In collaboration with outpatient agencies, survey collection occurs for a two-week period at each agency site. Collection will occur once a year, generally in May with appropriate agency and consumer follow-up between collection periods. Focus of follow-up will depend on survey results. Historically the focus has been around Quality and Outcome information.

Verity will provide the following:
- Confidential collection boxes for each agency site
- Satisfaction surveys in English and foreign language translations
- Data entry of surveys
- Verity Survey results

Agency expectations during collection period include the following:
- Pick up and drop off of confidential collection boxes at Verity identified location
- Confidentiality boxes and copies of MHSIP surveys should be provided in an easily accessible location for consumers.
- If consumers do not typically come in to the agency site, alternative collection methods should be determined with Verity Quality Management Staff.

Outcomes Report:
Agencies are expected to utilize an outcomes instrument (CANS or other Verity approved instrument) to aide in treatment planning. Agencies shall identify a Verity approved tool, determine how the tool will be used most effectively, and how information will be reported to Verity. A report of the full contract year's outcome information is expected at the end of the contract year.

REQUIRED REPORTS SUMMARY
(subject to individual contract)

REPORT TYPE	DUE DATE	METHOD OF TRANSMISSION	REPORT RECIPIENT
Outcomes Reports: - CANS-MH (child) - OQ-45 (adult) -YSS, YSS-F (child) - MHSIP (adult)	Outcomes Instrument Reporting: Annual, 60 days after fiscal year end. Satisfaction Survey: May distribution.	Outcomes: Hard copy mailed OR MHO.Reports@co.multnomah.or.us	Quality Management Coordinator 421 SW Oak St., Suite 520 Portland, OR 97204
Provider Specialty Report	**As of 7/1/09: Quarterly,** submit **30** calendar days after current **quarter**	Excel spreadsheet hardcopy or emailed: MHO.Reports@co.multnomah.or.us	Quality Management Coordinator 421 SW Oak St., Suite 520 Portland, OR 97204
Cultural Competency Internal Assessment only	Annual – January 2nd	Hard copy mailed OR MHO.Reports@co.multnomah.or.us	Quality Management Coordinator 421 SW Oak St., Suite 520 Portland, OR 97204
Quality Improvement Workplan	Within 60 days from effective date of contract	Hard copy mailed OR MHO.Reports@co.multnomah.or.us	Quality Management Coordinator 421 SW Oak St., Suite 520 Portland, OR 97204
Outpatient Access Reports (Adult/Child). Agency Referral Reports (Child)	15th calendar day of each month of contract. Quarterly, 30 days after quarter end.	Hard copy mailed OR MHO.Reports@co.multnomah.or.us	Quality Management Coordinator 421 SW Oak St., Suite 520 Portland, OR 97204
Provider Complaint Log	15th calendar day of each month of contract	Spreadsheet faxed OR MHO.Reports@co.multnomah.or.us	Quality Management Coordinator 421 SW Oak St., Suite 520 Portland, OR 97204

VERITY QUALITY MANAGEMENT COMMITTEE AND COUNTY ADVISORY BOARDS

QUALITY MANAGEMENT COMMITTEE

The mission of the Verity Quality Management (QM) Committee is to advise Verity on the continuous cycle of performance measurement standards, and continuous quality improvements of services and clinical outcomes for consumers. The QM Committee serves in an advisory capacity for Verity and its subcontractors and is designed to provide a forum for mutual information sharing and advocacy by individuals and provider organizations encompassing areas directly and professionally related to mental health.

The QM Committee is composed of 31 members who live or work within Multnomah County. Committee members identify, help to design, and review data for analysis for performance-based outcomes for the purpose of improving overall quality administrative/clinical outcomes for mental health consumers. The composition of the QM Committee is:

Verity QA/UR Clinical Manager
4 Verity Staff
1 Representative Hospital Provider
3 Representative Outpatient Providers
6 Verity Consumers and/or family members of Verity Consumers
3 Department of County Human Services (DCHS) Representatives
1 Representative of a Primary Health Plan
1 Representative of the Department of Health
1 Representative of the Department of Community Justice
1 Representative of the Department of Aging and Disability Services
1 Representative of the Department of Human Services (DHS)
1 Representative of the Oregon Youth Authority
1 Representative of CAMHSA
1 Representative of AMHSA

Verity has formed the Quality Management Committee for the following purposes:

- Identify indicators of quality
- Identify measurable and time specific performance objectives
- Identify data sources and methodology to measure performance
- Develop a process to systematically collect outcome data and identify staff who will collect and analyze data
- Oversee the data collection process
- Analyze the information collected and measure progress toward performance objectives
- Identify clinical and operational changes necessary to achieve performance objectives.
- Recommend implementation of clinical or operational changes that are indicated by the achievement or non-achievement of performance objectives
- Reassess and, if necessary, revise objectives and methods to measure performance on an on-going basis.

For additional information on Quality Management Committee activities, meeting schedules, membership or other Committee related issues contact: Quality Management Coordinator, Verity, 421 SW Oak Street, Suite 520, Portland, Oregon 97204, **(503) 988-5464.**

AMHSA

Adult Mental Health and Substance Abuse Behavioral Health Advisory Council (AMHSA)

This advisory council is the primary means that the community advises the local mental health authority. It also serves as the centerpoint for the local alcohol and drug planning process. It is composed of members of the community, such as consumers, consumer advocates, family members, providers, allied agencies, and interested citizens. The purpose of this group is to advise the county on policy for adults in mental health and substance abuse services. This committee assesses the unmet needs of the consumers and helps prioritize the County's resources to meet those needs.

This group focuses on policy, implementation, monitoring and evaluation. It also provides vision for the county as it plans for future projects. As the budgets are developed this group reviews them to provide input into the process.

CMHSAC

The Children's Mental Health System Advisory Council or CMHSAC is a State required advisory council that was put in place February of 2005. The purpose of CMHSAC is to make policy recommendations to ensure that Multnomah County achieves the intent of the State Children's Initiative, which is to provide flexible, culturally competent services to the highest need and most at risk children and their families in community based settings, allow for smooth transitions between higher levels of care, create better coordination of care across child serving systems, put families back in the driver's seat, and increase the availability of evidence based practices. The Initiative also calls for the provision of good assessments and prevention services to reduce the need for more high-end services.

The group is required to have at least 51% of its membership representative of family members, family advocates, and adolescent or young adult consumers. In addition, members will include system stakeholders such as juvenile justice, education, the State Department of Human Services (DHS), developmental disabilities, and other local stakeholders and advocates.

Mental Health and Addiction Services Division

Provider Manual

ATTACHMENTS

ATTACHMENT A

CULTURAL COMPETENCE
POLICY & PROCEDURE

QI WORKPLAN & CULTURAL COMPENTENCE
EVALUATION FORM

MULTNOMAH COUNTY OREGON

DEPARTMENT OF COUNTY HUMAN SERVICES
MENTAL HEALTH AND ADDICTION SERVICES DIVISION

SECTION: MHASD Administration	NUMBER: MHADM-170
TITLE: Cultural Competency	ORIGINATED: June 2007 REVIEW DATE: 6/08
APPROVED:	CONTACT PERSON: Karl Brimner PAGE 1 of 4

Applies to: All MHASD Staff, & MHASD subcontracted providers

1 Attachment:
Assessment Form

POLICY:

Cultural competency is a set of consistent behaviors, attitudes, policies, beliefs and practices that allow diverse individuals or groups to work effectively and efficiently in a cross-cultural environment. Proficiencies needed across all cultures require individuals and systems to develop and expand their ability to know about, be sensitive to, and have respect for cultural diversity. The result of this process should be an increased awareness, acceptance, valuing and utilization of and an openness to learn from general and health-related beliefs, practices, traditions, languages, religions, histories, and current needs of individuals and the cultural groups, to which they belong, including gender specific and sexual orientation.

The goal is to provide mental health and addiction care services that are respectful of and responsive to cultural and linguistic needs. Essential to cultural competency is appropriate and effective communication, which requires the willingness to listen and learn from members of diverse cultures and provision of services and information in appropriated languages, at appropriate comprehension and literacy levels, and in the context of individuals' cultural health beliefs and practices. "A culturally competent provider appreciates differences, is responsive to needs, and provides intuitive interventions." (Source: Los Angeles Kaiser Permanente Medical Center. 1994.) A culturally competent service provider is ultimately known by outcomes achieved and the services provided are valued by the people who go there for help.

Key steps in continuing to develop ongoing cultural competence in the system are:

Specialists: Establishing a core group of culturally competent mental health professionals to deliver services, and providing consultation and training.

Development: Building the service capacity and increasing funding for smaller culturally specific community-based agencies.

Training: Providing cultural competence training throughout the mental health system; training workers to provide a bridge to their communities; developing and recruiting additional culturally competent professional personnel.

Cross-System Exchange of Expertise: Developing partnership to use the Culturally Competency mental health professional expertise for client consultation with mainstream providers, and accessing a full range of services of all clients.

Baseline Expectations: While the five-racial ethnic communities (African American, Asian, Latino, Slavic, and American Indian/Native Alaskan) are committed to being accountable for the services they provide and the results they produce, they also have accountability expectations of the overall system and its various participants. The Mental Health system of care within Multnomah County must be built from a current baseline of service delivery. Racial/ethnic minority mental health specialist needs to be utilized to guide generalist providers and consult at critical treatment junctures: assessment, Intake, crisis services, placement into restrictive treatment, review or revision of Treatment & Services Coordination Plans, and discharge. All staff members are expected to have the following skills in cultural competency:

1. Open minded
   - Displays ability to be flexible
   - Displays ability for high tolerance of ambiguity
2. Cultural Empathy
   - Displays the ability to understand how cultural competencies are related to outcomes
   - Displays the ability to observe and react to other cultures with sensitivity

- Displays the ability to interpret and assess cultural differences
- Clinicians displays the ability to develop culturally competent treatment plans

3. Personal Autonomy
   - Displays a broad understanding of own culture and power differences that can affect interactions
   - Displays ability to seek accurate information respectfully if cultural knowledge is lacking
4. Emotional Resilience
   - Displays ability to manage the dynamics of difference, and are willing to examine alternatives to develop solutions for differences
5. Communication
   - Displays ability to expresses thoughts, ideas, and concerns clearly
   - Displays ability to listen attentively to others without interruption
   - Displays ability to use negotiation skills to settle conflicts

Outcome and Accountability: As a measure of accountability, the entire Mental Health service population should reflect the target population and its sub-groups; there should be comparable results across sub-groups. Consumers who are representative of racial/ethnic communities should be involved in shaping policy and accountability. Subcontracted providers will develop measures to continually assess whether the system is achieving major goals for comparable access, comparable outcomes, and culturally competent performance. All agencies submitting an application in response to an RFPQ will be required to complete a performance based, written cultural competency plan in accordance with Multnomah County Cultural Competence Standards and Self-Assessment.

Contracts with School Aged providers will require them to work directly with culturally specific provider organizations. If an ethnic or language or sexual minority youth or family is referred for mental health services, they will be offered the opportunity to receive these services through a culturally specific provider. The family will be informed of the availability of culturally specific services when the initial assessment occurs. Culturally specific provider agencies will not be required to contract with School Aged Contractors, and may provide mental health services to children and families through an independent working relationship with the County.

PURPOSE:

1. To eliminate discriminatory barriers for all who seek services from the MHASD; and to implement strategies that ensure equity of access.
2. To deliver services in a manner that provides culturally and linguistically appropriate care/ service and that is both sensitive and competent concerning the cultural differences of residents in our community.
3. To reduce racial, ethnic, gender and sexual orientation disparities in healthcare

PROCEDURES:

1. Contracting agencies will submit a performance based, written cultural competency plan in accordance with Multnomah County Cultural Competence Standards and Self-Assessment.
2. All correspondence will be provided in the client's language of choice including the client handbook, satisfaction survey and other written correspondence.
3. Interpreters will be available for any MHASD direct services

Agency:

Quality Management Plan

Domain	Excellent	Good	Fair	Missing	Comments
1. QM Structure	☐	☐	☐	☐	MHASD would like this section initially, then only when updated
2. Complaint/Grievance Process	☐	☐	☐	☐	
3. Credentialing	☐	☐	☐	☐	
4. Utilization Management	☐	☐	☐	☐	
5. Critical Incident Review	☐	☐	☐	☐	
6. Performance Measure					This section should be submitted annually.
• Are all domains covered?	☐	☐	☐	☐	
• Objective	☐	☐	☐	☐	
• Indicator	☐	☐	☐	☐	
• Performance Goal(s)	☐	☐	☐	☐	
• Measurement Method	☐	☐	☐	☐	
• Measurement Source	☐	☐	☐	☐	
• Action Steps	☐	☐	☐	☐	
• Action Steps Timeline	☐	☐	☐	☐	

Cultural Competency Plan

Domain	Excellent	Good	Fair	Missing	Comments
1. Non-discrimination Policy	☐	☐	☐	☐	
2. Agency assessment:	☐	☐	☐	☐	
• Staff reflect consumer population-recruitment & retention					
• Client access—Welcoming, and ADA accessible	☐	☐	☐	☐	
• Language: Written and translation	☐	☐	☐	☐	
• Cultural Competency, programs, services and individual staff	☐	☐	☐	☐	
• Referral and or outreach plans					
• Staff Training					
• Plan reviewed by staff and consumers annually	☐	☐	☐	☐	
• Are consumers able to provide input	☐	☐	☐	☐	
• Have Performance Measures been developed?	☐	☐	☐	☐	

ATTACHMENT B

QUALITY MANAGEMENT PROGRAM DESCRIPTION

MULTNOMAH COUNTY OREGON

DEPARTMENT OF COUNTY HUMAN SERVICES
MENTAL HEALTH AND ADDICTION SERVICES DIVISION
VERITY INTEGRATED BEHAVIORAL HEATLHCARE SYSTEMS

SECTION: MHASD Quality Management		NUMBER: QM-020
TITLE:	Quality Management Program Description	ORIGINATED: 10/03 REVIEW DATES: 6/04; 12/06, 6/07, 6/08
APPROVED:	CONTACT PERSON/S: Joan Rice, Charmaine Kinney	PAGE 1 of 3

Applies to: MHASD Staff, VIBHS Contracted Providers

Attachments: 0

POLICY GUIDELINES:

Quality Management Program Description:

The Mental Health and Addiction Services Division (MHASD) with the Mental Health Organization, (MHO) Verity Integrated Behavioral Healthcare System (VIBHS) is committed to its mission and goal to provide high quality services to Oregon Health Plan members of the VIBHS Plan. To this end, the Quality Management (QM) program utilizes total QM principles, with a continuous quality improvement systematic approach. The program is designed to monitor, evaluate, and improve the degree to which administrative, financial, operational, clinical and professional practices along with comparisons to performance outcomes.

The goals of the program are:

- Ensure the delivery of consumer care at the maximum achievable level of quality in a safe and cost-effective manner
- Design effective mechanisms for identifying, assessing, improving, and evaluating professional practices and reporting on the quality of care, it's effectiveness and consumer satisfaction
- Ensure that the Quality Management program is designed to provide staff with the support needed to deliver the best services possible with positive consumer and system outcomes

VIBHS supports and promotes a quality management program that is responsive to the service and demographic needs of all OHP members and VIBHS consumers.

1. *Quality Improvement:*

   Quality Improvement serves as a plan and guideline for quality monitoring and improvement activities. Verity develops and implements the annual quality improvement work plan covering the domains of Access to Service, Quality of Service Delivery, Integration and Coordination, Prevention/Education/Outreach, and Outcomes. Operational elements of the domains are to monitor and evaluate accessibility, capacity, clinical issues, and penetration rates and utilization of services. The use of data from various sources are complied, analyzed, and used to benchmark the domains. The Quality Improvement functions ensure the highest quality of clinical services to meet the needs of the consumer, ascertain accountability for financial issues, utilization, consumer satisfaction, and grievances.

2. *Quality Assurance*:

   Quality Assurance is a contractual requirement that MHASD must comply with in accordance with the Oregon Administrative Rules (OAR) and the Oregon Revised Statutes (ORS). Both rule and statute sets forth specifications for quality assessment and performance improvement strategies that the VIBHS and MHASD must implement to ensure the delivery of quality mental health care.

   In addition, performance measures are selected for each program offer to determine the efficiency and effectiveness of all Multnomah County programs. Performance measures for each program are driven by the program offer. The specific measure is determined by information gathered from consumer feedback systems, (satisfaction surveys, complaints, and membership on a variety of quality committees) and trends in aggregate data monitored to determine efficiency and effectiveness. Measures contain at least one outcome measure per program offer.

3. *Quality Management Committee*

   VIBHS establishes and maintains a quality management committee that performs a significant role in setting goals, benchmarks and quality indicators with input to the QI work plan and report. The committee is responsible for monitoring and reviewing data and information related to VIBHS quality management process and outcomes. The committee assesses on an ongoing basis the quality of care provided by the VIBHS mental health service contractors.

   The committee makes recommendations and acts as consultative body to VIBHS based on the reports and data that are presented to the committee. The committee meets monthly, ten months out of the year with the months of August and December off.

   The membership of the committee is comprised of mental health community providers, QMHPs, LMPs, stakeholders, and consumers and/or their representatives.

4. *Authority*

   The MHASD has the responsibility for quality management functions within the Division. The Quality Management Manager is authorized by the MHASD Director to implement the plan and shall have authority to take corrective action as indicated. The Quality Management Coordinator (QMC) under the direction of the QM Manager has the primary responsibility for the implementation of the Quality Management Plan including the overall coordination, development, and implementation and monitoring activities.

PROCEDURE:

Quality Improvement Process:

MHASD and VIBHS work conjointly to continuously monitor clinical performance, seeking opportunities for improvement. A variety of methods are used to identify relevant clinical issues affecting Verity members. To that end, Verity develops and implements additional procedures to improve the delivery and treatment systems.

1. Verity identifies relevant clinical issues affecting its members through various methods
   a. QM staff conduct member satisfaction surveys, through the contracted agencies
   b. Aggregate data presented to provider agencies. QM staff work with agencies to identify and clinically problem-solve utilization issues.

Quality Assurance Process:

The role of quality assurance is to continuously monitor, and evaluate the effectiveness of mental health and addiction services programs, ensure compliance with Federal/State rule and statutes, review and monitor service providers and provide oversight for corrective action.

1. Verity has in place a systemic process to select performance measures based on budget offers and collect data needed to:
    a. Review access to both outpatient care and acute care
    b. Regular treatment record reviews of certified mental health providers
    c. Review and trend all complaints/grievances/appeals and critical incidents
    d. Monitor corrective action plans
    e. Credentialing and Recredentialing mental health providers
    f. Report on under utilization of members by race/ethnicity and language

ATTACHMENT C

QUALITY MANAGEMENT
ADULT ABUSE REPORTING
POLICY & PROCEDURE

MULTNOMAH COUNTY OREGON

DEPARTMENT OF COUNTY HUMAN SERVICES
MENTAL HEALTH AND ADDICTION SERVICES DIVISION
VERITY INTEGRATED BEHAVIORAL HEATLHCARE SYSTEMS

SECTION: MHASD Quality Management		NUMBER: QM-001
TITLE:	Abuse Reporting	ORIGINATED: 7/1999 REVIEW DATES: 9/03, 6/04, 12/06
APPROVED:	CONTACT PERSON/S: Joan Rice, Charmaine Kinney	PAGE 1 of 3

Applies to: MHASD Staff, VIBHS Contracted Providers

Attachments: 0

POLICY GUIDELINE:
Verity Integrated Behavioral Healthcare Services (VIBHS) shall provide mental health agencies serving VIBHS members with an appropriate process for the identification, intervention, and reporting situations meeting definitions of Child Abuse or Abuse of adults who are mentally ill or developmentally disabled.

PROCEDURES:
1. It is the responsibility of the mental health provider serving VIBHS clients to ascertain if there is a reason to suspect neglect or abuse. It is not the mental health care provider's responsibility to decide whether or not there was actual abuse or neglect, nor who abused the client.

2. Child Abuse:
   A. Immediately upon becoming aware of potential abuse contact the DHS Child Welfare Child Abuse Hotline at 503-731-3100.
   B. Investigations will be conducted by State agency or by law enforcement.
   C. The Director/Clinical Supervisor of the contracted provider shall provide notice to VIBHS Quality Management in cases when the alleged perpetrator of abuse is any mental health agency staff person within 24 hours of knowledge of the event.

3. Adult Abuse (Mentally Ill):
   A. Immediately upon becoming aware of incident, VIBHS contracted providers shall report all incidents that meet the definitions of abuse as listed in the state statute and administrative rules to Multnomah County Mental Health and Addictions Services Division Abuse Investigators within 24 hours of the event.
   B. In cases of death by unnatural causes or case of abuse, Multnomah County Mental Health and Addictions Services Division Abuse Investigators will conduct an investigation according to Office of Investigation and Training procedure.

DEFINITIONS:
1. "Child Abuse" Definition: ORS 419F.005-419B.050
   A. Abuse means any assault of a child and any physical injury to a child which has been caused by other than accidental means, including any injury which appears to be at variance with the explanation given of the injury.
   B. Any mental injury to a child, which shall include only observable and substantial impairment of the child's mental or psychological ability to function caused by cruelty to the child, with due regard to the culture of the child.

C. Rape of child, which includes but is not limited to rape, sodomy, unlawful sexual penetration and incest.

D. Sexual exploitation, including but not limited to contributing to the sexual delinquency of a minor and any other conduct which allows, employs, authorizes, permits, induces or encourages a child to engage in the performing for people to observe, or the photographing, filming, tape recording, or other exhibition which in whole or part, depicts sexual conduct or contact. Allowing or permitting, encouraging or hiring a child to engage in prostitution.

E. Negligent treatment or maltreatment of a child, including but not limited to the failure to provide adequate food, clothing, shelter or medical care this is likely to endanger the health or welfare of the child.

F. Threatened harm to a child, which means subjecting a child to a substantial risk of harm to the child's health or welfare.

G. Buying or selling a person under 18 years of age.

H. A child who is a witness to domestic violence.

2. "Child" means an unmarried person under 18 years of age.

3. Requirements: Child Abuse Duty to Report ORS 419B.010
   Any public or private official having reasonable cause to believe that any child with who the office comes in contact has suffered abuse, or that any person with whom the official comes in contact has abused a child shall report or cause a report to be made to the appropriate authorities. Those public or private officials include physicians, dentist, school employee, licensed practical nurse or registered nurse, licensed clinical social worker, chiropractors, counselors and firefighters. A psychiatrist, psychologist, clergy person or attorney shall not be required to report information communicated to him/her by a person if the communication is privileged under ORS 40-225 to 40-295. A report is not an already established fact, but rather the request for assessment into the condition of the child.

4. "Adult Abuse" Definition: ORS 430.735-430.765, OAR 309-040-0005 -
   A. Any death caused by other than accidental or natural means or occurring in unusual circumstances;

   B. Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

   C. Willful infliction of physical pain or injury;

   D. Sexual harassment or exploitation including, but not limited to, any sexual contact between an employee of a community facility or community program, or provider, or other caregiver and the adult. For situations other than those involving an employee, provider, or other caregiver and an adult, sexual harassment or exploitation means unwelcome verbal or physical sexual contact including requests for sexual favors and other verbal or physical conduct directed toward the adult;

   E. Abuse may also include:

   F. Failure to act/neglect that leads to or is in imminent danger of causing physical injury, through negligent omission, treatment, or maltreatment of an adult, including but not limited to failure by a provider or staff to provide an adult with adequate food, clothing, shelter, medical care, supervision, or through condoning or permitting abuse of an adult by any other person. However, no person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment through prayer alone in lieu of medical treatment;

   G. Verbal mistreatment by subjecting an adult to the use of derogatory names, phrases, profanity, ridicule, harassment, coercion or intimidation and threatening injury or withholding of services or supports, including implied or direct threat of termination of services;

H. Placing restrictions on a resident's freedom of movement by seclusion in a locked room under any condition. Restriction to an area of the residence or restricting access to ordinarily accessible areas of the residence is not allowed, unless arranged for and agreed to on the Individual's Support Plan or Personal Care Plan;

I. Using physical restraints without a written physician's order, or as part of an Individual Support Plan, unless a resident's actions present an imminent danger to himself/herself or others, and only until appropriate action is taken by medical, emergency, or police personnel;

J. Financial exploitation which may include, but is not limited to, unauthorized rate increases, staff borrowing from or loaning money to residents, witnessing wills in which the caregiver is beneficiary, adding caregiver's name to resident's bank accounts or other personal property without approval of the individual or his/her guardian and the ISP team or PCP; and

K. Inappropriately expending a resident's personal funds, theft of a resident's personal funds, using a resident's personal funds for staff's own benefit, commingling resident's funds with caregiver or other resident's funds, or the caregiver becoming guardian or conservator.

5. Requirements: Abuse Adults Who Are Mentally Ill or Developmentally Disabled Duty to Report ORS 430.765
   A. Any public or private official who has reasonable cause to believe that any adult with whom the official comes in contact while acting in an official capacity, has suffered abuse, or that any person with whom the official comes in contact while acting in an official capacity has abused an adult shall report or cause a report to be made in the manner required in ORS 430.743.

   B. A psychiatrist, psychologist, member of the clergy or attorney shall not be required to report such information communicated by a person if the communication is privileged under ORS 40.225 to 40.295.

   C. An adult who in good faith is voluntarily under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall for this reason alone not be considered subjected to abuse under ORS 430.735 to 430.765. [1991 c.744 §§3,11

ATTACHMENT D

CONTRACTOR REPORTING COMPLIANCE POLICY & PROCEDURE

MULTNOMAH COUNTY OREGON

DEPARTMENT OF COUNTY HUMAN SERVICES
MENTAL HEALTH AND ADDICTION SERVICES DIVISION
VERITY INTEGRATED BEHAVIORAL HEALTHCARE SYSTEMS

SECTION: Administration		NUMBER: AD-015
TITLE:	Contractor Reporting Compliance	ORIGINATED: 12/02 REVIEW DATE: 6/04; 1/06; 6/07; 6/08
APPROVED:	CONTACT PERSON/S: David Hidalgo, LCSW	PAGE 1 of 2

Applies to: MHASD Staff, MHASD/VIBHS Contracted Providers

1 Attachment:
Required Report Summary

POLICY GUIDELINE:

Contractors with Multnomah County Mental Health and Addiction Services (MHASD) are obligated to submit timely and accurate reports as outlined within the Multnomah County contracts, Quality Management Plan and the MHASD Provider Manual, which serves an instructional purpose.

The collection of information from Contractors regarding the service delivery system is in the interest of mental health consumers by allowing the development of a system responsive to Consumer needs and satisfaction.

Further, the enforcement of reporting requirements as part of a compliance program provides the County with information to assure both the State and ultimately the taxpayer of the efficient expenditure of funds for mental health and addiction services.

Therefore this policy and procedure outlines the steps that can be taken by the County in the enforcement of the reporting requirements of all MHASD service contracts.

PROCEDURE:

I. MHASD Quality Management staff will maintain contract specific files for each contractor noting the required reporting for the contractor and the timely submission of such reports.

A. Monthly Status Report: Each month, no later than the 15th of the month, a comprehensive notice will be distributed to all contracted providers, noting:
1) all reports received and missing (if any) from the Provider
2) on-going due dates of such reports, and
3) applicable delays in sending data to the State

B. Notice to Providers of Overdue Reports: The monthly Required Reports Summary will serve as notice to the Provider of any overdue reports. Providers are considered out of compliance for any required report not received by due dates listed in contract, unless an extension has been

agreed upon with the Compliance Coordinator. Extension requests can be submitted by email to MHO.Reports@co.multnomah.or.us.

C. The Compliance Coordinator will meet with the Division MHO Manager and Division Business Manager with a report of all Providers who are out of compliance as of the 20th of the month. The Business Manager will contact the CFO of each Provider agency to give them a final due date, noting this date on the Compliance Coordinator's report, before automatic withholding will begin the first of the following month.

II. Reduction of Payment (Withhold): Upon reaching the due date without receipt of overdue reporting, the MHO Manager will coordinate with the Business Manager and the Division's Third Party Administrator to apply an 8% reduction of the total agency payment beginning the following month's payment. This reduction of service payment shall continue until the Provider no longer has overdue reports.

Upon receipt of all overdue reporting, Verity will refund 5% of the total amount withheld during the period of non-compliance.

Providers can avoid a reduction by:

A. Providing proof the required reporting has been sent to the County, or

B. Request an appeal with the MHASD Director contesting the required report, or

(Note: if the requested appeal is denied, the 8% reduction will apply retrospectively to the date of the first service payment following the Status Report listing the overdue report.)

C. Schedule a technical assistance (TA) meeting with the Compliance Coordinator within three weeks of the Status Report listing the outstanding reports.

III. Technical Assistance Meeting: The Compliance Coordinator will participate in any scheduled Technical Assistance meetings with Providers at their earliest convenience to develop a Corrective Plan for Provider in a collaborative effort. The Corrective Plan will list:

A. Overdue reports by type and date rang

B. Any information required from the County to complete the report

C. Provider or County perceived concerns or barriers

D. Agreed date for submission of each overdue report

E. Agreed date by which overdue reports will be submitted to County or Section II of this policy will be in effect until all reporting is timely.

The Compliance Coordinator and/or Business Operations staff will track on-going withhold payments via the Clinical Integration Manager (CIM) Authorization Database maintained by the Division's Third Party Administrator.

ATTACHMENT E

AUTHORIZATIONS FOR
MULTNOMAH TREATMENT FUNDED SERVICES

MULTNOMAH COUNTY OREGON

DEPARTMENT OF COUNTY HUMAN SERVICES
MENTAL HEALTH AND ADDICTION SERVICES DIVISION
VERITY INTEGRATED BEHAVIORAL HEALTHCARE SYSTEMS (VIBHS)

SECTION: Administration		NUMBER: BA-050 Previous No: AD-030
TITLE:	Internal Processing of Authorizations for Multnomah Treatment Funded Services	ORIGINATED: 4/12/04 REVIEW DATES: 5/04; 8/04; 10/05; 3/06; 7/07; 12/07; 6/08, 7/09
APPROVED:	CONTACT PERSON/S: David Hidalgo, LCSW	PAGE 1 of 3

Applies to: VIBHS Contracted Entities

4 Attachments:
MTF Authorization Request Form
MTF Adult Clinical Checklist
Financial Verification Form
LOCUS/CASII Score Sheet

POLICY GUIDELINE:

The Multnomah Treatment Fund (MTF) is a safety net program for children and adults who do not qualify for Oregon Health Plan Standard or Plus benefits due to income or lack of documentation of legal residency; whose family income is below 200% of the Federal Poverty level, who have no mental health insurance benefit, are unable to pay for services on their own, **AND** who meet the clinical criteria outlined in ORS 430.675:

"Priority 1 is defined as those persons who, in accordance with the assessment of professionals in the field of mental health, are at immediate risk of hospitalization for the treatment of mental or emotional disorders, or are in need of continuing services to avoid hospitalization, or pose a hazard to the health and safety of others, and those persons under 18 years who, in accordance with the assessment of professionals in the field of mental health, are at immediate risk of removal from their homes for treatment of mental or emotional disturbances, or exhibit behavior indicating high risk of developing disturbances of a severe or persistent nature."

Adults will meet clinical criteria for MTF if they are in imminent jeopardy of loss or removal of children due to their mental disorder and/or at risk of homelessness, incarceration, hospitalization, or dangerousness. In addition, criteria will be meet for adult clients currently prescribed Clozaril or intramuscular medication for his/her psychiatric disorder; or (at re-authorization) the adult client has a HAP Shelter-Plus Voucher, and the requesting provider has demonstrated attempts to locate non-MTF funded community-based treatment service and has not been successful and there is a strong possibility that the client will significantly decompensate without ongoing treatment services.

MTF may also be used as a funding source while individuals are obtaining OHP coverage or whose coverage has lapsed provided that they meet clinical criteria as outlined above.

PROCEDURE:

These safety net funds will be made available via Multnomah County contracted outpatient mental health agencies. For individual cases that may qualify for the above criteria, clinicians within these contracted providers will be responsible for making a clinical determination as well as a financial screening before formally requesting these funds.

The goal of offering this funding is to allow these providers to eliminate or reduce the above risks to consumers in Multnomah County. Contracted providers will be given the opportunity to request exceptions to the stated financial criteria and/or insurance status above in order to fulfill this goal. Special consideration will be given to individual cases that fall outside the above **financial** parameters for approved MTF.

I. PROVIDER PROCESSING: Upon determining eligibility, a designee within the contracted provider agency will forward the following paperwork to Verity Business Services:

A. **New and on-going clients**:
All clinical paperwork and Financial Verification Form must be completed and dated within 60 days of a request.
1. MTF Authorization Request Form
2. Financial Verification Form
3. MTF Adult Clinical Checklist
4. Mental Health Assessment (for children only)
5. Clinical Formulation (for children only)
6. Treatment Plan demonstrating the client's **continued** Priority One status and plan for intensive community based services designed to reduce the risk of higher levels of care (for children only.)
7. For adults, a LOCUS assessment score. For children, a CASII assessment score.
8. **If requesting a financial exception: Explanation of Benefits (EOB) or statement of private insurance coverage as appropriate.**

B. **Adult psychiatric services: <u>eligibility valid only if previous MTF authorization approved.</u>**
All clinical paperwork and Financial Verification Form must be completed and dated within 60 days of a request.
1. MTF Authorization Request Form
2. MTF Adult Clinical Checklist
3. LOCUS score
4. Financial Verification Form
5. **If requesting a financial exception: Explanation of Benefits (EOB) or statement of private insurance coverage as appropriate.**

II. The Financial Verification Form must be updated with each additional request for MTF. (Note: if the clinician requests an Indigent Client Pharmacy authorization for this same client, an **updated** Financial Verification Form MUST accompany the request for medication also.)

III. INTERNAL PROCESS: Upon receipt of a MTF Request, Verity staff will confirm that a Multnomah County address is listed for the identified client (note: provider may specify homelessness as appropriate).

A. **Adult & Child requests:** If approved, Verity staff will initiate an authorization. Adult consumers will be authorized for up to 12 months of MTF coverage. Child consumers will be authorized for up to 6

months of MTF coverage. If denied, documentation will be faxed back to requesting agency explaining reason(s) the request was denied.

Note: Appeals for reconsideration of a denial are made by contacting a System of Care Manager to request a second review of the original documentation. Providers are asked not to fax more information to Multnomah County if a MTF request is denied. Providers are responsible for successful description planning for a consumer who is not authorized for MTF.

B. **All provider requests for financial exception shall require a review by a System of Care Manager.**

Within 15 days of the receipt of such documentation, county staff will determine the client's eligibility and notify agency whether client continues to be eligible.

IV. ADULT MTF AUDITING: Submission of clinical documentation for pre-authorization consideration is not required for **adult** MTF requests. However, the Mental Health and Addiction Services Division shall perform regularly scheduled clinical chart audits for adult MTF clients according to parameters below:

A. Each quarter, the Adult System of Care Coordinator, in conjunction with the Division Quality Management Team shall run a list of adults with MTF authorizations open in the previous 6 month period.
B. From the list, a random sample will be pulled for a full clinical appropriateness audit
C. The Adult Care Coordinator will give 14 day notice of on-site clinical chart audit to each participating provider, including a list of randomized client charts to provide for auditing.
D. The Adult Care Coordinator will utilize the existing adult clinical chart audit tool for outpatient services. Results will be compiled with the Quality Management Team and shared with each participating provider in the form of consultation and a summary report.